

PLEASE PRINT

**PATIENT INFORMATION**

Patient's Name: \_\_\_\_\_ Date \_\_\_\_\_  
Last First Middle Initial

Birthday \_\_\_\_\_ Age \_\_\_\_\_ Sex:  M  F CELL PHONE \_\_\_\_\_

\_\_\_\_\_ Street Address City

\_\_\_\_\_ State Zip Code Home Phone With Area Code

**RESPONSIBLE PARTY (PARTY TO BE BILLED)**

\_\_\_\_\_ Last Name First Name Middle Initial

\_\_\_\_\_ Telephone with Area Code Date of Birth Social Security Number

\_\_\_\_\_ Street Address (if different from patient)

\_\_\_\_\_ City State Zip

\_\_\_\_\_ Responsible Party Employer Work Phone With Area Code

\_\_\_\_\_ Spouse Name if Married Employer Work Phone With Area Code

**AUTHORIZATION/RESPONSIBILITY AGREEMENT**

I have requested Farmington Dermatologists, PC, David A. Baird, MD to bill my insurance company for all covered services on my behalf. I clearly understand that it is my responsibility to ensure that payments for services rendered are collected in a reasonable amount of time. I hereby authorize any insurance company to pay the proceeds of any of my benefits due directly to Farmington Dermatologists, PC and Dr. David A. Baird. A copy of this can be considered as an original for insurance purposes.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

In order to process a claim for benefits, I authorize Farmington Dermatologists, PC and Dr. David A. Baird to release to any insurance company information regarding my medical history, examination, treatment and diagnostic tests. A photocopy of this authorization shall be considered as effective and valid as the original.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ Name Phone with area code

REFERRED BY: \_\_\_\_\_