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 is 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: _____