South Charlotte Dermatology

PATIENT INFORMATION

☞ = Mandatory Information

☞ Name:	☞ Date of Birth:
☞ Address: ☞ Apt #	☞ Social Security #:
☞ City:	☞ Sex:
☞ State: Zip:	☞ Employer: ☞ Occupation:
☞ Home Phone:	☞ Cell Phone:
☞ Referring Doctor:	☞ Emergency Contact: ☞ Phone #:

GUARANTOR INFORMATION

Name:	Date of Birth:
Address:	Social Security:
City:	Employer:
State: Zip:	Employer Address:
Home Phone:	Employer City:
Cell Phone:	Employer State: Zip:

* Please Note We DO NOT Accept Medicaid

INSURANCE INFORMATION

Primary Insurance:	Secondary Insurance:
Certificate#:	Certificate:
Group Number:	Group Number:
Group Name:	Group Name:
Specialist Copay $:	Specialist Copay $:
Subscriber Name:	Subscriber Name:
Subscriber Date of Birth:	Subscriber Date of Birth:

Authorization To Pay Benefits To Physician: I authorize the release of medical or other information necessary to process health insurance claims. I also request payment of benefits to myself or to my Provider, Dr. David B. Schulman, M.D. when he accepts assignment.

Authorization To Release Medical Information. I hereby authorize my Provider, Dr. David B. Schulman, M.D. to release any information necessary for my course of treatment.

_____ _____

Signed (patient or parent if minor) **Date**