Pt. Acct. # _____
F.D. Initial _____

# CENTRAL OHIO SKIN AND CANCER, INC.

**Patient Information** (Please Print Clearly)

Name_____ Employer_____Occupation_____
Last First MI
Address_____ Address_____

City_____ State____ Zip Code _____ Phone # ( )_____

Phone # ( ) _____ Family Doctor _____

SSN _____M ___ F ___ Phone # ( ) _____

DOB_____Age_____ Marital Status M S W D Referring Doctor_____

Spouse's Name _____ Phone # ( ) _____

Family member previously seen in our office _____

**Emergency Contact** (Nearest friend or relative not residing with patient)

Name_____

Address _____

Phone # ( ) _____

**Guarantor Information** (Responsible party i.e. parent or legal guardian)

Name_____ Employer_____

Relationship_____ Address_____

Address (if different)_____ Phone # ( ) _____

City _____State_____ Zip Code_____

Phone #_____

**Primary Insurance Information**

Insurance Comp._____

Policy Holder _____

Relationship_____

SSN _____DOB_____

Employer Name & Phone #_____

ID/Subscriber #_____

Group #_____

Copay_____

**Secondary Insurance Information**

Insurance Comp._____

Policy Holder_____

Relationship_____

SSN_____DOB_____

Employer Name & Phone #_____

ID/Subscriber #_____

Group #_____

Copay_____

The undersigned hereby authorizes treatment of the above named patient. I/we agree to promptly pay all charges for the patient, at the time of service unless other arrangements have been made with the billing office. The undersigned hereby authorizes release of any information pertaining to a claim filed with his or her insurance company. Central Ohio Skin & Cancer, Inc. is not responsible for procedures not covered by your insurance company. We will provide you with a statement. You are responsible for the bill.

Signature_____Date_____

Pt reviewed_____Date_____

Pt reviewed_____Date_____

Pt reviewed_____Date_____

Pt reviewed_____Date_____