MARY RUTH BUCHNESS MD, DERMATOLGIST, PC

PATIENT INFORMATION

Please write clearly…

Patient Account #

Patient Name: _____ Name Called By: _____
First Middle Last

Address: _____ _____ _____ _____
Street/Apt # City State Zip

Phone: _____ Birth Date: _____ SS #:_____ Email: _____
Cell: _____
☐ATT ☐VERIZON ☐SPRINT ☐T-MOBILE
☐ Male ☐ Female ☐ Single ☐ Married ☐Divorced ☐ Widow ☐Partner other family members seen in office: _____
Race: _____ Ethnicity: _____
How did you hear about our office? ☐ Phone Book ☐ Insurance Company ☐ Other _____

Primary Care Physician: _____ Referred By :_____
Primary Care Physician Phone: _____ Pharmacy Name & Number: _____

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

Spouse: _____ SS #: _____ Occupation: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____ Phone:_____

Please complete if patient is a minor…

Father/Guardian: _____ **Mother/Guardian**: _____

Employer: _____ Phone: _____ Employer: _____ Phone: _____

Responsible Party: ☐ Self ☐ Spouse ☐ Father/Guardian ☐ Mother/Guardian

1. **Primary Insurance**: _____ ☐ HMO ☐ POS ☐ PPO ☐ Indemnity ☐ Other _____

Insured's Name: _____ Birth Date: _____ Effective Date: _____

☐ Self ☐ Spouse ☐ Father/Guardian ☐ Mother/Guardian Co Pay Amount: $_____ Annual Deductible: $_____

Member ID #: _____ Group # or Employer Name: _____

Claims Address: _____ Phone:_____

2. **Secondary Insurance**: _____ ☐ HMO ☐ POS ☐ PPO ☐ Indemnity ☐ Other _____

Insured's Name: _____ Birth Date: _____ Effective Date:_____

☐ Self ☐ Spouse ☐ Father/Guardian ☐ Mother/Guardian Co Pay Amount: $_____ Annual Deductible: $_____

Member ID #: _____ Group # or Employer Name: _____

Claims Address: _____ Phone:_____

Medicare #: _____ Medicaid # _____

I authorize any holder of medical or other information about me to release to any carrier or the Social Security Administration and CMS or its intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____
Date Signature of Patient or Parent if a Minor

I authorize payment of insurance benefits, otherwise payable to me, directly to MARY RUTH BUCHNESS MD, DERMATOLOGIST, PC

_____ _____
Date Signature of Patient or Parent if a Minor

Method of payment for today's co-payment, deductible and/or co-insurance: ☐ Cash ☐ Check ☐ Major Credit Card