64040 HWY 434, Suite #103
Lacombe, LA 70445
Phone: (985) 202-3376 Fax: (985)________

PATIENT INFORMATION

Patient Name: ____ Title:: Mr./Mrs./Dr./Other:________________________ Suffix:____________

Gender: _______________________ Date of Birth:____________________________ Social Security #:______________________________

Mailing Address:_____________________________________ City:_________________________ State:__________ Zip:_____________

Preferred Phone: (Cell / Home / Work):_______________________Other Phone: (Cell / Home /Work) ______________________________

Marital Status:___________________________ Occupation:_______________________ Language:_____________ Race:______________

Primary Care Physician:___________________________________ Referred by:____

Email (Optional: **IF you would like to subscribe to monthly specials, marketing, etc*):____

EMERGENCY CONTACT

Name:_____________________________ Relationship to Patient:__________________________ Phone:___________________________

INSURANCE INFORMATION

SEND STATEMENT TO: (If different from above)

Name: ____ Title:: Mr./Mrs./Dr./Other:________________________ Suffix:_________________

Mailing Address:_____________________________________ City:_________________________ State:__________ Zip:_____________

Preferred Phone: (Cell / Home / Work):_______________________Other Phone: (Cell / Home /Work) ______________________________

PRIMARY INSURANCE:

Insurance Company:___________________________________ ID#_________________________________ Group#___________________

Insured Name(Subscriber):_______________________________ DOB:_________________________ Social security#____________________

Patient's Relationship to Insured (Subscriber): *SELF* *SPOUSE* *CHILD* *OTHER*

SECONDARY INSURANCE:

Insurance Company:___________________________________ ID#_________________________________ Group#___________________

Insured Name(subscriber):_______________________________ DOB:_________________________ Social security#____________________

Patient's Relationship to Insured (subscriber): *SELF* *SPOUSE* *CHILD* *OTHER*

I hereby authorize that the above listed insurance companies to pay directly to Malinski Dermatology due me, as provided in the above unexpired policy I will pay all charges in excess of whatever sums may be allowed by my insurance and acknowledge amounts due from me, outstanding greater than 90 days will be eligible for collections. I authorize Malinski Dermatology to release information to the insurance company for my claims to be paid. Please attach a copy of my insurance card.

____ ____

Signature Date