

INTERMOUNTAIN DERMATOLOGY
1951 Bench Road * Pocatello, ID 83202 * (208) 238-7001

PATIENT INFORMATION

Name(Last,First, Initial)_____ Date_____

Address_____ City, State, Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Social Security Number_____ Sex_____ Date of Birth_____

Referred By_____

Marital Status:

1-Married 2-Single 4-Other 5-Widow 6-Separated 7-Divorced

Spouse/ Parent's name_____ Date of Birth_____

Emergency Contact_____ Relationship_____ Phone #_____

(not living with you)

PRIMARY RESPONSIBLE PARTY

(Statements will be sent to this person)

Name(Last,First, Initial)_____ Date_____

Address_____ City, State, Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Social Security Number_____ Sex_____ Date of Birth_____

Employment Status:

1-Full Time 2-Part Time 3-Retired 4-Unemployed 5-FT Student 6-PT Student

Employed by:_____ Phone Number_____

INSURANCE INFORMATION

We are contracted with: BlueCross, BlueShield, DMBA, IHC, Medicaid, Medicare, SIPHO/MRI , Beech Street, IPN and UPREHS

Primary Insurance_____ Effective Date_____

Address_____

City, State, Zip_____ Phone#_____

Policy Holder's Name_____ Date of Birth_____ Sex_____

Group Number_____ Policy Number_____

Employer_____

Secondary Insurance_____ Effective Date_____

Address_____

City, State, Zip_____ Phone#_____

Policy Holder's Name_____ Date of Birth_____ Sex_____

Group Number_____ Policy Number_____

Employer_____

ASSIGNMENT AND RELEASE:

_____ NON MEDICARE: I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I authorize the physician to release any information required to process this claim

_____ MEDICARE: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Family Practice Group, P.A. for any services furnished me by that practice. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formally the Health Care Financing Administration and it's agents any information needed to determine these benefits or the benefits payable for related services.

Signature_____ Date_____