

**PATIENT INFORMATION**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date \_\_\_\_\_  
 Home Address \_\_\_\_\_ Home Telephone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Work Telephone \_\_\_\_\_ Alt / Cell Phone \_\_\_\_\_ E-Mail \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Sex M F Marital Status \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 If Married – Name of Spouse \_\_\_\_\_  
 If Minor – Name of Parents \_\_\_\_\_  
 Person Financially Responsible for Patient \_\_\_\_\_ Relationship \_\_\_\_\_  
 Do you have an advanced directive for health care? Y N Allergies \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_  
 Whom May We Thank for Referring You \_\_\_\_\_ HIPAA Read / Signed Y N

**PRIMARY INSURANCE**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Address (if different from patient) \_\_\_\_\_  
 Insured's Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Insured's Employer \_\_\_\_\_ Work Telephone \_\_\_\_\_  
 Insurance Plan Name \_\_\_\_\_ Plan Telephone \_\_\_\_\_  
 Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
 Co – Pay \_\_\_\_\_ Deductible \_\_\_\_\_ Type of Plan \_\_\_\_\_  
 Are you familiar with coverage limitations of your plan? \_\_\_\_\_

**SECONDARY INSURANCE**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
 Address (if different from patient) \_\_\_\_\_  
 Insured's Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Insured's Employer \_\_\_\_\_ Work Telephone \_\_\_\_\_  
 Insurance Plan Name \_\_\_\_\_  
 Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_  
 Co – Pay \_\_\_\_\_ Deductible \_\_\_\_\_ Type of Plan \_\_\_\_\_  
 Are you familiar with coverage limitations of your plan? \_\_\_\_\_

**ASSIGNMENT OF MEDICARE BENEFITS**

I request that payment of authorized Medicare benefits be made to me or on my behalf to Koger Dermatology & Anderson Foot Care for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services. This authorization is in effect for my lifetime, or until I choose to revoke it.  
 Signed \_\_\_\_\_ Date \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS**

I request that payment of authorized insurance benefits be made to me or on my behalf to Koger Dermatology & Anderson Foot Care for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the \_\_\_\_\_ (name of insurance company) and its agents any information needed to determine benefits payable for related services. This authorization is in effect for my lifetime, or until I choose to revoke it.  
 Signed \_\_\_\_\_ Date \_\_\_\_\_