AGLOW DERMATOLOGY - DINA STRACHAN, MD, PC

PATIENT INFORMATION (PLEASE PRINT/Name /DOB and a copy of your insurance Card(s) Required)

LAST NAME (legal):	FIRST (Legal)		MIDDLE
STREET ADDRESS:		CITY & STATE:	ZIP:
HOME PHONE / WORK PHONE	CELL:	DATE OF BIRTH:	SEX M F
SSN: / EMAIL ADDRESS:		MARITAL STATUS M S W D SEP	EMPLOYMENT WORKING STUDENT RETIRED
Primary Care Physician:	WERE YOU REFERRED?: Y N	Name of the REFERRING physician is:	

PERSON RESPONSIBLE FOR PAYMENT

LAST NAME:	FIRST & MIDDLE NAME	RELATIONSHIP TO PATIENT SELF SPOUSE FATHER MOTHER OTHER_____

COMPLETE IF PATIENT IS A MINOR OR DEPENDENT STUDENT (CIRCLE RELATIONSHIP)

FATHER/STEP-FATHER/GUARDIAN: LAST NAME:	FIRST & MIDDLE NAME	SS#:
STREET ADDRESS:	CITY & STATE:	ZIP:
EMPLOYER:	WORK PHONE NUMBER ( )	
EMPLOYER'S STREET ADDRESS:	CITY & STATE:	ZIP:
MOTHER/STEP-MOTHER/GUARDIAN: LAST NAME:	FIRST & MIDDLE NAME	SS#:
STREET ADDRESS:	CITY & STATE:	ZIP:
EMPLOYER:	WORK PHONE NUMBER ( )	
EMPLOYER'S STREET ADDRESS:	CITY & STATE:	ZIP:

PRIMARY INSURANCE (Insured's Name, Date of Birth and Relationship to pateint are required)

INSURANCE COMPANY NAME:	CIRCLE ONE: HMO PPO POS EPO INDEMNITY
POLICYHOLDER'S NAME / DATE OF BIRTH:	RELATIONSHIP OF PATIENT TO POLICYHOLDER: SELF SPOUSE CHILD OTHER _____

SECONDARY INSURANCE (Insured's Name, Date of Birth and Relationship to pateint are required)

INSURANCE COMPANY NAME:	CIRCLE ONE: HMO PPO POS EPO INDEMNITY
POLICYHOLDER'S NAME / DATE OF BIRTH:	RELATIONSHIP OF PATIENT TO POLICYHOLDER: SELF SPOUSE CHILD OTHER _____

I understand that **I am financially responsible** for all services rendered. If I am covered by an insurance company that requires a referral from my primary care physician, it is my responsibility to obtain that referral authorization prior to my visit. I will pay the charges I am responsible for today, whether it is a copayment, deductible, coinsurance or payment in full.

NO SHOW POLICY - I understand that Aglow Dermatology and Dina Strachan, MD require a 24 hour notification of cancellation and a $50.00 charge will be billed to me if I fail to cancel my appointment.

PAYMENT AUTHORIZATION: I authorize insurance payment, if any, directly to Aglow Dermatology and Dina Strachan, MD, PC. I realize I am responsible for non-covered services.

INFORMATION RELEASE: I authorize Aglow Dermatology & Dina Strachan, MD, PC, to release to my Insurance Carrier any information needed to determine benefits payable to the related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Dina Strachan, MD, PC

Signature (parent, if patient is a minor) **X** _____ **Date** _____