Jeffrey N. Thompson, D.O.
www.thompsonderm.com

PATIENT____Age_______
(Last) (First)

Address_______________________________________City________________State______ Zip________

Date of Birth________Male/Female____Marital Status________1. Work/Cell Phone________________________
2. Home Phone____________________________

Social Security Number________________________________Employer_______________________________

Name of Requesting Consultation____

RESPONSIBLE PARTY (if different from patient)

Name__________________________ ________________________________Age__________
(Last) (First) (Middle)

Address______________________________ City________________State_______Zip_______________

Date of Birth______________Male/Female_____Marital Status_____ 1. Work/Cell_____________________

Employer____2. Home Phone___________________

Relationship to Patient____

Pharmacy Name______________________________________**Location**____________________________

PRIMARY INSURANCE____

SECONDARY INSURANCE____

IS THIS A WORKER'S COMP CLAIM?_______Claim #____________Date of Injury/Illness_____________

DOES YOUR INSURANCE REQUIRE PRE-CERTIFICATION?______Deductible/Co pay Amount $_______

I authorize the release of any medical information necessary to process any insurance claim. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I also authorize payment of medical insurance benefits directly to my physician. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY INSURANCE POLICY.** I have completed the above answers and certify that this information is true and correct to the best of my knowledge.

**********<u>**Because scheduling is an important part of our practice, there will be a $30.00 cancellation fee for any appointment not canceled or rescheduled with less than a 24 hour notice**</u>**********

____ ___________________________
Responsible Party Signature Date