

Dermatology Associates of West Michigan

Provider: RJA DCD BJB RJL JEM DDS KJG KAS

PLEASE PRINT CLEARLY

Referring Doctor: _____
First and Last Name City, State Phone #

Name _____ Male ___ Female ___ Birth Date ___/___/___
Last First Initial

Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work (_____) _____ Cell (_____) _____
(Please check the box next to the phone number where you would like to receive appointment reminder calls)

E-Mail Address: _____ Social Security # _____

I have received a Notice of Privacy Practices from D.A.W.M. Initial _____ Date _____

May we leave personal medical information on your answering machine at home? ___ Yes ___ No

How did you hear about us? Radio ___ Advance ___ GRPress ___ Internet Website ___ Family/Friend ___ Other ___

May we mail or e-mail you special offers? ___ Yes ___ No

Do you give our office permission to discuss your medical information with others (family, friend, etc)?
___ Yes ___ No If yes, please provide their name(s) and phone number(s) below.

Name: _____ Relationship: _____ Phone # _____

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Primary – Insurance Company: Ins. Co. Name _____

Name of Policy Holder (Insured): _____ Holder's Date of Birth: ___/___/___

Your relationship to Policy Holder (circle one) Self Spouse Dependent

Policy Holder's Social Security #: _____

Secondary – Insurance Company: Ins. Co. Name _____

Name of Policy Holder (Insured): _____ Holder's Date of Birth: ___/___/___

Your relationship to Policy Holder (circle one) Self Spouse Dependent

Policy Holder's Social Security #: _____

In case of an emergency, who should be notified? _____

Relationship: _____ Phone #: (_____) _____

Payment Policy

Priority Health, BCBS, Blue Care Network, Blue Choice, Medicare, Tricare, PhysiciansCare, Cofinity: You will be responsible for paying your co-payment, annual deductible and charges for any non-covered, cosmetic services.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not contracted will be required to pay 100% of the total bill at the time of the service.

_____/_____/_____
Patient or Responsible Party Signature Date

Please present insurance card(s) and photo ID to the receptionist so copies may be made.