

**Dayton Skin Surgery Center
500 Lincoln Park Blvd. Ste. 200
Kettering, OH 45429
937-293-5567**

PATIENT INFORMATION (PLEASE PRINT) TODAY'S DATE ___/___/___

Name _____
(FIRST) (MIDDLE) (LAST)
Address _____ City _____ State _____ Zip Code _____
Home Phone (____) _____ Work Phone (____) _____ Cell (____) _____
Email: _____ Have you been seen here before? Yes ___ No ___
Referred to us by: _____ Primary Care Physician _____
SS# _____ Date of Birth ___/___/___ Age _____ Sex: M F

RESPONSIBLE PARTY (if different from patient)

Name _____
Address _____
Home Phone (____) _____ Work Phone (____) _____ Cell (____) _____
SS# _____ Date of Birth ___/___/___ Age _____ Sex: M F

INSURANCE INFORMATION (please present insurance card at time of check in)

Primary Insurance Name _____	Secondary Insurance Name _____
Ins. Address _____	Ins. Address _____
Name of Insured _____	Name of Insured _____
Insured Date of Birth ___/___/___	Insured Date of Birth ___/___/___
Insured's ID # _____	Insured's ID # _____
Group # _____	Group # _____
Relationship of patient to insured _____	Relationship of patient to insured _____
Employer name _____	Employer name _____
Employer address _____	Employer address _____
Employer phone (____) _____	Employer phone (____) _____
In case of Emergency, who should be notified? _____ Phone (____) _____	

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient Signature _____ **Date** ___/___/___

The following are the **Financial Policies** of Dayton Skin Surgery Center. Payment is required for all services at the time they are rendered. For managed care patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. You are required to pay any unmet deductible, non-covered services, and co-payments. A \$30.00 fee will be added to your account for returned checks. Nonpayment of your account balance will result in collections and credit damage. Your signature below signifies your understanding and willingness to comply with this policy. You also authorize DSSC to release any requested medical information to your insurance company, the Social Security Administration and Health Care Financing Administration or its intermediaries needed for this or a related Medicare or Medigap claim. I permit a copy of this authorization to be used in place of the original.

Patient Signature _____ **Date** ___/___/___