IDAHO SKIN INSTITUTE

147 W Chubbuck Rd·Chubbuck, ID 83202
Clinic: 208-238-SKIN (7546)·Fax: 208-237-9643

PATIENT INFORMATION

Name (Last, First, Initial)_____Date_____
Social Security Number_____Date of Birth _____Sex [M] [F]
Address _____City, State, Zip_____
Race: [ ]-White [ ]-Hispanic [ ]-Black [ ]-American Indian [ ]-Asian Preferred Language: [ ] English or Other_____
Marital Status: [ ]-Married [ ]-Single [ ]-Other [ ]-Widow [ ]-Separated [ ]-Divorced
Referred By_____
Home Phone_____Work Phone_____Cell Phone_____
E-mail Address:_____
Employment Status: [ ]-Full Time [ ]-Part Time [ ]-Retired [ ]-Unemployed [ ]-Full Time Student [ ]-Part Time Student
Employed By:_____Employer Phone:_____
Spouse/Parent's Name_____Date of Birth_____
Emergency Contact_____Relationship_____Phone# _____
(not living with you)

PRIMARY RESPONSIBLE PARTY

(Statements will be sent to this person)

Name (Last, First, Initial)_____Relationship_____
Address_____City, State, Zip_____
Home Phone_____Work Phone_____Cell Phone_____
*Social Security Number_____Sex_____Date of Birth_____
Employed By:_____Employer Phone:_____.

INSURANCE INFORMATION

We are contracted with: Blue Cross, Blue Shield, DMBA, IHC, Medicaid, Medicare, SIPHO/MRI, Beech Street, IPN, and UPREHS
For accurate billing to insurance, we will request a copy of your insurance card for our files.

Primary Insurance_____ Policy Holder's Name _____
Policy Holder's Date of Birth_____Sex_____ Employer_____
Group #:_____ Policy# _____
Secondary Insurance _____Policy Holder's Name_____
Policy Holder's Date of Birth_____ Sex_____ Employer_____
Group #:_____ Policy #:_____

ASSIGNMENT AND RELEASE:

Please initial next to the line that is appropriate

Initial Below

_____**NON MEDICARE:** I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I authorize the physician to release any information required to process my claim.

_____**MEDICARE:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to Idaho Skin Institute for any services furnished me by that practice. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formally the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

AUTHORIZATION/ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & FINANCIAL POLICY

I, (name of patient)_____, acknowledge and agree that I have read a copy of Idaho Skin Institute's Notice of Privacy Practices and Financial Policy.

_____ _____
Patient Signature Date

_____ _____
Patient Legal Representative (if applicable) Date

_____ _____
Print Name of Legal Representative Date