

Steve Oberemok MD Inc.

Name: _____

Date of Birth: ____/____/____ Age: _____ Sex: _____ Marital Status: _____

Mailing Address: _____

City, State, Zip Code: _____

Primary Phone #: _____ Secondary Phone #: _____

Is it ok to leave a message?: _____ Is it ok to leave a message with anyone other than you?: _____

If yes, whom may we leave a message with? _____

PRIMARY/ REFERRING PHYSICIAN: _____

INCASE OF EMERGENCY CONTACT OR PARENTS NAME IF PATIENT IS A MINOR

Name: _____ Phone #: _____ Relationship _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Secondary Insurance Co. _____

Name of Insured: _____ Name of Insured _____

Date of Birth _____ Date of Birth _____

ID # or Social Security # _____ ID # or Social Security # _____

It is the patient's responsibility to know and understand their own insurance benefits. This office will attempt to verify benefits but is not responsible for misinformation or interpretation of benefits. The patient will be responsible for deductibles, co-insurance and non-covered services. The patient will be responsible for all services for out-of-network claims. The patient will be responsible for all services denied by insurance due to 'No Eligibility', 'Non Covered Service', 'Pre Authorization/Certification Not Obtained'. It is the patient's responsibility to inform this office of any change of information i.e. Address, telephone, insurance, etc. Statements are released after your insurance pays, denies, or non-payment by your insurance. If you do not feel your insurance processed your claim according to your benefits you should contact your insurance. I authorize the release of medical information to my primary care or referring physician as necessary for insurance claims, prescriptions, etc.

Collections

If it is necessary to assign your account to a collections agency, you will be responsible for all of our collection agency fees.

I HAVE READ THE ABOVE AND FULLY UNDERSTAND MY RESPONSIBILITY. I ALSO ACKNOWLEDGE THAT I HAVE BEEN PRESENTED WITH THE NOTICE OF PRIVACY PRACTICES FOR THE OFFICE OF HEMET DERMATOLOGY, STEVE OBEREMOK, M.D. INC

SIGNATURE: _____ **DATE:** _____