Steve Oberemok MD Inc.

Name:____ Date: ____/____/______

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? ____

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 # ______________________

Referred By: _______________________________ Primary Physician: __________________________

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:_________________________