

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: _____ Date of Birth: ___/___/___ Relationship _____

INSURANCE INFORMATION

Primary Insurance Co. _____ Secondary Insurance Co. _____

Name of Insured: _____ Name of Insured: _____

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. It is the patient's responsibility to inform this office if your insurance requires pre certification or pre authorization of services prior to scheduling of such services. 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.

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:** _____

