

# Spartanburg Dermatology & Skin Surgery Clinic, P.C.

2020 North Church Place • Spartanburg, S.C. 29303

## INFORMATION SHEET

NEW  UPDATE

DATE: _____ PHYSICIAN: _____ CHART #: _____ • FOR OFFICE USE ONLY •	HOW DID YOU LEARN ABOUT US? _____ _____ REFERRED BY: _____ _____
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### PATIENT INFORMATION

NAME (FIRST, MI, LAST) \_\_\_\_\_  
STREET ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
HOME PHONE # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SEX \_\_\_\_\_  
MARITAL STATUS \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ PHONE # \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
STUDENT:  YES  NO IF STUDENT:  FULL-TIME  PART-TIME

### RESPONSIBLE PARTY

NAME (FIRST, MI, LAST) \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
PHONE # \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_

### OTHER INFORMATION

CONTACT PERSON NOT LIVING WITH YOU \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_ PHONE # \_\_\_\_\_  
IF PATIENT IS MARRIED, SPOUSE'S NAME \_\_\_\_\_ WORK # \_\_\_\_\_  
IF PATIENT IS A CHILD, FATHER'S NAME \_\_\_\_\_ WORK # \_\_\_\_\_  
MOTHER'S NAME \_\_\_\_\_ WORK # \_\_\_\_\_

### INSURANCE INFORMATION

PRIMARY \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
GROUP # \_\_\_\_\_ POLICY # \_\_\_\_\_  
IF HMO, PRIMARY CARE PHYSICIAN \_\_\_\_\_  
POLICY HOLDER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
SEX (M/F) \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
EMPLOYER \_\_\_\_\_  
SECONDARY \_\_\_\_\_ EFFECTIVE DATE \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_  
GROUP # \_\_\_\_\_ POLICY # \_\_\_\_\_  
IF HMO, PRIMARY CARE PHYSICIAN \_\_\_\_\_  
POLICY HOLDER \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
SEX (M/F) \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_  
EMPLOYER \_\_\_\_\_

\*\*\*\*\* PLEASE READ AND SIGN ON THE OTHER SIDE \*\*\*\*\*

**STATEMENT TO ASSIGN MEDICARE BENEFITS TO PHYSICIAN OR SUPPLIER**

Patient's Name: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

"I request that payment of authorized Medicare Benefits be made on my behalf to Spartanburg Dermatology and Skin Surgery clinic, P.C. for any services furnished to me by my physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**STATEMENT TO ASSIGN MEDIGAP BENEFITS TO PHYSICIAN OR SUPPLIER  
(Medicare Supplemental Insurance)**

"I authorize Medicare to file my supplemental (Medigap) insurance. I request that payment be made to Spartanburg Dermatology & Skin Surgery Clinic, P.C. for any services furnished to me by that physician. I authorize the release of any medical information necessary to process this claim."

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Supplemental Insurance Co.: \_\_\_\_\_

**STATEMENT OF FINANCIAL RESPONSIBILITY**

I understand that my insurance(s) may not cover the entire cost of all services received in this office, therefore, I recognize that ultimate financial responsibility for my account remains mine. I hereby guarantee payment in full of any and all charges for services rendered not covered by any health benefits plan, including all deductible and coinsurance amounts.

Signature of  
Patient/Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_