



# Hemet Dermatology Inc

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[www.hemet-dermatology.com](http://www.hemet-dermatology.com)

**PATIENT INFORMATION**

TODAY'S DATE \_\_\_\_\_

Name \_\_\_\_\_  
Last First M.I.

Mailing Address \_\_\_\_\_  
City State Zip

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

**SPOUSE'S INFORMATION ( Parent's information if patient is a minor )**

Name \_\_\_\_\_  
Last First M.I.

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone \_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Co. \_\_\_\_\_ Secondary Insurance Co. \_\_\_\_\_

Name of Insured \_\_\_\_\_ Name of Insured \_\_\_\_\_

ID or Social Security # \_\_\_\_\_ ID or Social Security # \_\_\_\_\_

In Case of Emergency, who should be notified? \_\_\_\_\_

Referred by: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

I authorize the release of medical information to my primary care or referring physician, to consultants as needed and as necessary to process insurance claims, and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_

Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, all applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_\_