Laborde Dermatology, P.A.

PATIENT INFORMATION (PLEASE PRINT)

Last Name First Name Middle Initial	Birth Date	Sex	Social Security Number

Responsible Party (Guarantor)	Marital Status: ☐ Single ☐ Married ☐ Widowed

Mailing Address	Street	City	State	Country	Zip Code

Telephone Number	Cell Number	Work Number	Best Number to Reach You

Drivers License Number	Email address

Occupation / Employer (Self)	Employer (Spouse)
Business Address (Self)	Business Address (Spouse)
Business Phone (Self) ( )	Business Phone (Spouse) ( )

IN CASE OF EMERGENCY CONTACT: (Name of friend or relative not living with you)

Last Name First Name Middle Initial	Relationship	Home Phone ( )
Address, City, State, Zip Code		Business Phone ( )

HEALTH INSURANCE INFORMATION: In order to process your insurance claim, you must present your insurance card at the time of service. Failure to do so may result in denial of your claim. Please understand that you are financially responsible for all charges, whether or not paid by your insurance. Verification of coverage is not a guarantee of payment.

Name of **Primary** Insurance Company, Group Name and Address			Telephone Number ( )
Policy Number or Subscriber ID Number	Group Number	Name of Policy Holder	Relationship (to policy holder) ☐ Self ☐ Spouse ☐ Other
Name of **Secondary** Insurance Company, Group Name and Address			Telephone Number ( )
Policy Number or Subscriber ID Number	Group Number	Name of Policy Holder	Relationship (to policy holder) ☐ Self ☐ Spouse ☐ Other

SIGNATURE ______________________________ **DATE** ______________________