BABICH SKIN CARE
PATIENT INFORMATION

Name: _____Sex F/M
Last First
Middle
Date of Birth___/ ____/ ____Social Security # _____

Address _____
Street City State Zip
Home Phone # _____Work Phone # _____

Marital Status: Single _____ Married _____ Divorced_____ Widowed _____

Employer _____ Occupation _____

Insurance Company Name _____

Policy Holder Name _____

Policy Holder Date of Birth ___/____/____ Social Security #_____

If Patient is a Minor Indicate Responsible Party/Guardian	
Responsible Party	Legal Guardian
SS#	SS#
Employer	Employer
Work Phone	Work Phone
Occupation	Occupation
Address	Address

Emergency Contact: _____
(List someone not in your household) Name Phone
Relationship

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. Your signature below signifies that you authorize Babich Skin Care to release all medical information required by your insurance may be billed for these services; you remain responsible for any and all charges incurred for your visit to this practice. Furthermore, in the event of any legal or other such action necessary to collect any monies owed to the practice on your account, you will be responsible for attorney fees, court costs, or any collection expenses incurred by the practice. Minors are not responsible for payment and are not required to sign this sheet only responsible party.

Signature: _____ Date: _____