

**WASHINGTON DERMATOLOGY CENTER
RONALD PRUSSICK, M.D., P.C.**

Last Name: _____ First Name: _____ M.I. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Tel: _____ Emergency Contact & Tel: _____

Birthdate (M/D/Y): _____ Age: _____ O MALE O FEMALE

Social Sec. No.: _____ Occupation: _____ O SINGLE O MARRIED O PARTNER

Employer: _____

Office Tel: _____ Cell Phone: _____

Email: _____ Whom may we thank for referring you to our office? _____

YES **NO** I would like to receive information on promotional material or discounts.

INSURANCE INFORMATION

PRIMARY INSURANCE

SECONDARY (IF ANY)

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD

Primary Ins. Co: _____

Secondary Ins. Co: _____

Subscriber Name: _____

Subscriber Name: _____

Birthdate (M/D/Y) _____

Birthdate (M/D/Y): _____

Policy #: _____

Policy#: _____

Group #: _____

Group #: _____

Effective Date: _____

Effective Date: _____

Relationship to Patient (Please Circle):

Relationship to Patient (Please Circle):

1-SELF 2-SPOUSE 3-PARENT

1- SELF 2- SPOUSE 3- PARENT

PATIENT AUTHORIZATION

I hereby authorize Ronald Prussick, M.D.,P.C. and associates to apply for benefits on my behalf for covered services rendered and request that payments from my health insurer be made directly to Ronald Prussick, M.D.,P.C. I further authorize the release of any necessary information, including medical, to Ronald Prussick, M.D.,P.C. and/or my health insurer (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration). I certify that the information I have reported with regard to my insurance coverage is correct and I permit a copy of facsimile of this authorization to be used in place of the original. This authorization may be revoked at any time in writing.

PATIENTS ARE RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED. WE PROVIDE COMPLEMENTARY INSURANCE BILLING SERVICES FOR YOU BUT WILL NOT ASSUME RESPONSIBILITY FOR COLLECTION.

Subscriber or Beneficiary/Patient/Guardian

Date

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