

**Society Hill Dermatology
932 Pine Street
Philadelphia, PA 19107
215-829-6861**

Information is Confidential

Patient Information Form

Referred by _____ Date _____

Patient's Name _____ Age _____
(last) (first) (middle)

Social Security# _____ Marital Status _____ Date of Birth _____

Address _____
(street) (city) (zip)

Home Phone (____) _____ Work Phone (____) _____

Cell Phone (____) _____ Email Address _____

Employer _____ Address _____

Occupation _____

Contact name and number in case of emergency:

Name _____ Number _____

Must be filled in:

Guarantor's Name _____ Date of Birth _____
(name of policy holder)

Address _____ Phone Number (____) _____

ALL CO-PAYS ARE DUE ON THE DAY OF YOUR VISIT. IF YOU DO NOT HAVE YOUR CO-PAY, YOU WILL BE ASKED TO RESCHEDULE YOUR VISIT.

Please Check Insurance carrier: _____ Keystone East _____ Aetna _____ Medicare
_____ Personal Choice _____ Blue Shield (**We do not accept Horizon or BCBS/PEBTF**)

We do not accept reimbursement from any other carrier.

In the event of an outstanding balance, your account will be forwarded to a collection agency if greater than sixty (60) days past due.

Your signature below indicates you are the responsible party for payment of all services rendered.

Date _____ Signature _____