Wallace of Beverly Hills
DERMATOLOGY

PATIENT INFORMATION

_____
Patient's last name | First Name | Middle

☐Mr. ☐Miss ☐Mrs. ☐Ms.

☐Marital Status (circle one)
Single / Mar / Div / Sep / Widow

_____
Is this your legal name? ☐Yes ☐No | If not, what is your legal name? | (Former name):

Birth date: ___/___/___ Age: ____ Sex: ☐M ☐F

_____
Street Address | Social Security No.

Home Phone No.: Primary # ☐
(_____) _____ - _____

_____
City | State | Zip Code | Email Address

Work Phone No.: Primary # ☐
(_____) _____ - _____

_____
Occupation | Employer

Cell Phone No.: Primary # ☐
(_____) _____ - _____

How were you referred to Wallace Medical Group? (please check one box):
☐ Dr. _____ ☐ Insurance Plan ☐Hospital ☐ Close to home/work ☐Yellow Pages ☐Family/Friend seen here

Pharmacy Phone: (____) _____ - _____ May we leave results on primary phone voicemail? ☐Yes ☐No

INSURANCE INFORMATION

(Please give your insurance card to the Receptionst)

Is this patient covered by insurance? ☐Yes ☐No Name of primary insurance: _____

☐ Medicare # _____ ☐ Medi-Cal # _____ ☐ PPO ☐ HMO

_____/___/_____$___._____
Subscriber's name | Subscriber's S.S. No. | Birth Date | Group No. | Policy No. | Co-pay

Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):

_____
Subscriber's name | Group No. | Policy No.

Patient's relationship to subscriber ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

_____ (____) ____ - _____ (____) ____ - _____
Name of local friend or relative (not living at same address) | Relationship to patient | Home phone | Work phone

ASSIGNMENT OF BENEFITS

Wallace Medical Group are pleased to accept your assignment of insurance subject to the verification of benefits by your insurance company. We will file your claim forms on your behalf in order to assist you in every possible way. It is, however hereby understood that insurance contracts are between you (the patient) and your insurance company, you are responsible for any amount not paid by your insurance company. All patients are required to pay all of their insurance contract obligations, such as: Annual deductibles, office and treatment co-payment amounts a portion of which may be due at time of service. This is determined based upon your insurance eligibility prior to your service, but final determination is made by your insurance once they have received and processed your claim.

I, the patient, intend by this assignment and designation of authorized representative to convey to WMG all of my right to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to 1) obtain information regarding the claim to the same extent as me; 2) submit evidence; 3) make statements about facts or law; 4) make any request including providing or receiving any such health care benefit plain, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

I have read and understand the contents herein and hereby agree to abide by these conditions, including my assignment of any and all insurance benefits to WMG provided to me by WMG.

_____ _____
Parent/Guardian Signature | Date