King Dermatology
675 HWY 62 E Ste 1
Mountain Home, AR 72653
Telephone: 870-425-5464   Fax: 870-425-5465

Patient Information Form

Patient Name____
Last First MI

Date of Birth:______/______/_________ **Gender: M__F__ Social Security #:**________________________________

Mailing Address:____
City State Zip

Home Phone:____________________ **Cell Phone:**____________________ **Work Phone:**______________________

OK to Leave Msg: Home____ Cell___ Work___ Email Address:_____________________________

Please Circle One
Marital Status: Single Married Divorced Widowed

Race: White Hispanic Black/African American Other Race

Ethnicity: Hispanic or Latin Not Hispanic or Latin Refuse to report

Language: English Indian Spanish Russian Other

Employer Name:_______________________________ **Address:**____

Primary Insurance:____ **Policy Holder:**________________________
Policy Holder Date of Birth:______/_____/_______ **Policy Holder Social Security #:**_________________________
Policy Holder's Employer:____________________________________ **Employer Phone:**________________________

Secondary Insurance:____ **Policy Holder:**________________________
Policy Holder Date of Birth:______/_____/_______ **Policy Holder Social Security #:**_________________________
Policy Holder's Employer:____________________________________ **Employer Phone:**________________________

Emergency Contact Name:____________________________________ **Phone Number:**__________________________
Relationship:_____________________________ **Address (if different):**_____________________________________

Parent /Guardian Name/POA:__________________________________ **Phone Number:**________________________
Address:____**Date of Birth:**________________________

Benefits Assignment and Records Release

I hereby authorize the assignment of benefits (payments) directly to King Dermatology for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party:____Date:______________________