BAY POINTE DERMATOLOGY AND COSMETIC CENTER, P.A.
JANICE LIMA-MARIBONA, DO

Date: _____ Patient's Name: _____ Date of Birth:_____
Address: _____City: _____ State: ____ Zip:_____
Home Phone: _____ Work: _____ Cell:_____
Patient's Social Security: _____ Email address: _____
Gender: ◊ Male ◊ Female Marital Status: ◊ Single ◊ Married ◊ Divorced ◊ Widowed

Spouse's Name: _____ Telephone: _____
In case of an emergency, notify: _____
Telephone:_____ Relationship: _____

Primary Care/Referring physician: _____ Telephone: _____

****

- If patient is a child please fill out this section

- Mother's Name:_____ Date of Birth: _____
  Address: _____Telephone: _____
  Work: _____ Cellular: _____ Social Security: _____
  Employers Name: _____ Telephone: _____
- Father's Name _____ Date of Birth: _____
  Address:_____ Telephone: _____
  Work: _____ Cellular: _____ Social Security: _____
  Employers Name: _____ Telephone: _____

****

Do you have medical insurance? ◊ Yes ◊ No Do you have more than one Insurance Policy? ◊ Yes ◊ No

Name of primary insurance: _____
Identification #: _____ Group #:_____
Insured's Name: _____ D.O.B: _____ Relationship_____

Name of secondary insurance: _____
Identification #: _____ Group #:_____
Insured's Name: _____ D.O.B: _____ Relationship_____

- If you have Medicare or Medicaid, please provide us with the following.
- Medicare Id # _____ Medicaid ID # _____

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE ABOVE NAMED PROVIDER OF PROFESSIONAL SERVICES RENDERED.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY FOR CLAIM PROCESSING.

SIGNATURE: _____ DATE: _____

Patient or Parent of Minor