255 Kirts Blvd, Ste 100
Troy, MI 48084
(248) 244-8448 Fax (248) 244-8766
WWW.SOMERSETSKINCENTRE.COM

SOMERSET SKIN CENTRE

PATIENT INFORMATION

Date: ____________ Social Security #: ____________

Name: ______________________________
Last Name First Name Middle Initial

Address: ______________________________

City: ______________________________

State: ________ Zip: ____________

Sex: ☐M ☐F Age: _____ Birthdate: ____/____/_____

☐ Widowed ☐Single ☐ Divorced ☐ Married

Contact Info: May we leave a message?

Home Phone ____________ ☐ Yes ☐ No

Work Phone ____________ ☐ Yes ☐ No

Cell Phone ____________ ☐ Yes ☐ No

Email ____________ ☐ Yes ☐ No

Preferred method of contact? ____________

Referring Physician Name and Address: ____________

Referring Physician's Phone: ____________

Primary Care Physican Name/Address: (If different) ____________

Primary Care Physician's Phone: ____________

In case of emergency, person(s) to notify: ____________

Emergency Contact's Phone: ____________

PRIMARY INSURANCE

Cardholder's Name: (Person responsible for account) ____________

Relation to Patient: ____________

Address: (If different from Patient's) ____________

Phone: ____________

Insurance Co.: ____________

Soc.Sec #: ____________

Cardholder Employer: ____________

Birthdate: ____________

Employer's Address: ____________

Employer Phone: ____________

Occupation : ____________

How did you hear about Somerset Skin Centre?

☐ Radio Station? Which one? ____________

☐ Yellow Pages

☐ Printed Ad Name of Publication: ____________

☐ SSC patient? Whom may we thank? ____________

☐ Other ____________

I certify that I, and/or my dependent(s), have insurance coverage with ______________________ and
Name of Insurance Company(ies)
assign directly to Dr. Murakawa all insurance benefits, If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Murakawa may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits for the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________________ ______________ ______________
Signature of Patient, Parent, Guardian or Personal Representative Relationship to Patient Date