Commerce Institute of Skin

Annette C. LaCasse, D.O.

PATIENT INFORMATION

Allergies to Medication:_____ DATE:_____

_____ BIRTHDATE:_____

FEMALE: PREGNANT? YES ☐ NO ☐ S.S.#_____

PLEASE PRINT CLEARLY

PATIENTS FULL NAME_____ AGE_____SEX_____
Last First Middle Initial

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE ( )_____OCCUPATION_____

EMPLOYED BY_____PHONE ( )_____

REFERRED BY_____SPOUSE'S NAME_____

CELL PHONE ( )_____

PERSON RESPONSIBLE FOR ACCOUNT_____

ADDRESS_____

CITY_____STATE_____ZIP_____

PHONE ( )_____RELATIONSHIP_____

CELL PHONE ( )_____

PRIMARY INSURANCE INFORMATION: BC/BS ☐ MEDICARE ☐ OTHER ☐

SUBSCRIBER NAME_____DATE OF BIRTH_____

CONTRACT #_____

GROUP #_____COVERAGE CODE #_____

INSURANCE ADDRESS_____

EMPLOYER_____PHONE ( )_____

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SECONDARY INSURANCE INFORMATION: BC/BS ☐ MEDICARE ☐ OTHER ☐

SUBSCRIBER NAME_____DATE OF BIRTH_____

CONTRACT #_____

GROUP #_____COVERAGE CODE #_____

INSURANCE ADDRESS_____

EMPLOYER_____PHONE ( )_____

I UNDERSTAND THAT THE OFFICE OF DR. LACASSE MAY BILL THE INSURANCE COMPANY FOR ANY PROCEDURES/SURGERIES RENDERED. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THESE CLAIMS WITHIN THE CALENDER YEAR. I WILL BE RESPONSIBLE FOR ANY UNPAID BALANCES.

SIGNED_____