



**Dr. Alexander Zemtsov • Dr. Lisa Wilson
Laine Elam, P.A.**

Certified by the American Boards of Dermatology and Quality Assurance

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Patient Information

Today's Date: ____/____/____

Name: _____
Last First MI

Prefer to be called: _____ Title: Miss Mrs.
 Ms. Mr.

Address: _____
City State Zip

Mailing Address: _____

Home Phone: (____) _____ Sex: M F SSN#: _____
area code

Marital Status: Single Married Divorced Widowed Date of Birth: ____/____/____

Who is your family Doctor? _____

Employer Name: _____ Phone Number (____) _____
area code

Employer Address: _____

Emergency Information

Emergency Contact: _____ Emergency Phone (____) _____
area code

Parent or Responsible Party Information (If patient is a minor - This area is regarding the parent with the child today.)

Name: _____
Last First MI

Address: _____
City State Zip

Home Phone: (____) _____ Work Phone: (____) _____
area code area code

SSN#: _____ Date of Birth: ____/____/____ Sex: M F

Insurance Information (Please present insurance card at time of check-in)

MEDICARE

Member's Name _____

Medicare Number: _____

PRIMARY Insurance Name

Insurance Address _____

Name of Insured/Date of Birth _____

Insured's ID# and/or SSN _____

Group# and/or Plan# _____

Employer Name _____

Employer Address _____

Employer Phone _____

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Relationship of patient to the Insured _____

Other family members that are patients _____

Pharmacy of choice _____

Phone _____

SECONDARY Insurance Name

Insurance Address _____

Name of Insured/Date of Birth _____

Insured's ID# and/or SSN _____

Group# and/or Plan# _____

Employer Name _____

Employer Address _____

Employer Phone _____

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Relationship of patient to the Insured _____

Other family members that are patients _____

Pharmacy of choice _____

Phone _____

How did you hear about our office (Circle one) Family - Friend - Physician - Yellow Pages - Ins - Internet - Other _____

Referring Physician _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date: _____ / _____ / _____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductible, non-covered services and copayments. Should your account become past due, you will be responsible to pay all collection costs. This includes collection agency fees, attorney fees, and all court costs. The collection fee is arrived by taking your past due balance and dividing it by .65%. This new amount will be placed with our collection agency and become your responsibility to pay.

CANCELLATION POLICY: University Dermatology Center does require a 24 hour notice for cancelations. We reserve the right to charge a \$10.00 fee to any patient who does not give at least a 24 hour notice. _____Initials

Patient or Responsible Party Signature _____ Date: _____ / _____ / _____

Copy of insurance card (both sides) attached.

Updated by: _____