

**INNOVATIVE DERMATOLOGY**

**INSURANCE INFORMATION**

Insurance Company Name: \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_

Social Security # of Policy Holder: \_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
MM DD YEAR

ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Referred By: Doctor Patient Yellow Pages Other (circle one)

Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**I HAVE RECEIVED AND I UNDERSTAND THE INNOVATIVE DERMATOLOGY OFFICE  
POLICIES AND PRIVACY PRACTICES REGARDING THE PRIVACY OF MY MEDICAL  
INFORMATION AND RECORDS.**

\_\_\_\_\_  
Patient or Authorized Person Signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date