

PLEASE PRINT

Patient's Name _____ Sex _____

Address _____

City _____ State _____ Zip _____

Date of birth _____ Age _____ Social Security _____

Home Phone _____ Cel Phone _____ Work Phone _____

Referred by _____ Family Doctor _____

Regular Medications: _____

Drug Allergies _____

Previous Operations _____

Employer _____

Employer's Address _____

Insurance Company _____

Policy Number _____ Group Number _____

Policy Holder's Name _____

Present Complaint _____

(If you are seeing Dr. Bandeian about a mole or skin lesion that is changing, state how it is changing.)

If Accident, Date of Accident _____ Description of Accident _____

If your visit is not covered by insurance, payment is expected at time of service. If you are required to make a co-payment, this amount must be paid at the time of service. If your insurance is billed for the medical services, you will be billed for any balance due. If applicable, your balance due will be reduced by the terms of your insurance company's contract with Dr. Bandeian. Dr. Bandeian participates with Medicare. **It is your responsibility to verify that Dr. Bandeian participates in your medical insurance plan. If Dr. Bandeian does not participate in your medical insurance plan, you will be responsible for the entire bill for his services to you.**

I authorize release of any information acquired in the course of my examination and or treatment to my insurance company and request payment directly to Dr. Bandeian of any benefits due for services rendered. I recognize and accept personal responsibility for any balance remaining after payment of such benefits. I give Dr. Bandeian permission to take pictures of me and to use them for educational purposes.

Patient's (or guardian's) Signature _____ Date _____