

ELK GROVE
DERMATOLOGY, S.C.
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Elk Grove, Illinois 60007
(847) 593-6222

Robert B. Polisky, M.D.
Board Certified in Dermatology
American Society for Dermatologic Surgery

www.dermatologist-polisky.com

PATIENT INFORMATION

Name: _____
Last First M.I.

Date of Birth: ____/____/____ Sex: Male Female SSN: _____

Mailing Address: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

E-mail: _____ Marital Status: _____

Referred By: _____

Primary Care Physician: _____ Phone: () _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)

Name: _____
Last First M.I.

Mailing Address: _____

Home Phone: () _____ Work Phone: () _____

INSURANCE CARRIER INFORMATION

Primary Insurance Carrier: _____

Policy Holder's Name: _____ Date of Birth _____

Secondary Insurance Carrier: _____

Policy Holder's Name: _____ Date of Birth _____

EMERGENCY CONTACT INFORMATION

In case of Emergency, who should be notified? _____

Relationship: _____ Phone: () _____

Do you give our office permission to discuss your medical information with family members?

YES NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____ Phone: () _____

Name: _____ Relationship: _____ Phone: () _____

May we leave personal information on your answering machine or cell phone? YES NO

I hereby authorize Elk Grove Dermatology to release information regarding care rendered. Should an insurance claim be filed by Elk Grove Dermatology, I authorize payment of benefits to go directly to Elk Grove Dermatology. **I understand that I will be responsible for any and all charges not covered by my insurance company. In addition, I acknowledge that all no-shows or cancellations made less than 24 hours prior to the time of service will incur a \$20.00 fee.**

Signature _____

Date _____