



1455 N. Milwaukee Avenue
2nd Floor
Chicago, IL 60622

Last Name: _____ First Name: _____ Middle Initial: _____

Mailing Address (include city, state, and zip): _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

OK to leave message with test results at home: _____ work: _____ cell: _____

Social Security Number: _____ Date of Birth: _____

Marital Status: _____ Occupation: _____

Employer Name: _____ Work Phone: _____

Employer Address: _____

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Fax Number: _____

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to Dermatology & Aesthetics of Wicker Park for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of service.

Signature of Responsible Party: _____ Date: _____

Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Responsible Party: _____ Date: _____