Medical & Surgical Dermatology, LLC
52 Hospital Drive, Suite 3A
Columbus, NC 28722
(828) 894-2473 I FAX (828) 894-2390

Westgate DERMATOLOGY
2430 Reidville Road
Spartanburg, SC 29301
Voice to Email: 904.664.8644

CHART #_____

DATE_____

PETER J. NEIDENBACH, M.D.
Amy B. Mitchell, PA-C | Chad A. York, PA-C

PATIENT INFORMATION

Name_____ Social Security #_____

Address_____ Telephone #_____

City_____State_____ Zip_____ Cell Phone #_____

Sex ____M ____F Age____ Birthdate_____ Marital Status_____

Email_____ Occupation_____

Patient Employed By_____ Bus. Phone_____

In case of emergency, notify_____ Telephone #_____

PRIMARY INSURANCE

Name of insurance company_____

Address of insurance company_____

Phone # of insurance company_____

Subscriber name_____S.S. #_____ DOB_____

Certificate #_____ Group #_____ Employer_____

SECONDARY INSURANCE

Name of insurance company_____

Address of insurance company_____

Phone # of insurance company_____

Subscriber name_____S.S. #_____ DOB_____

Certificate #_____ Group #_____ Employer_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance with _____ (name of insurance company) and assign directly to Medical & Surgical Dermatology all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that if my insurance requires a prior authorization before receiving services, then it is my responsibility to obtain the authorization or I will be financially responsible for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize use of this signature on all insurance forms.

Responsible party signature_____ Date_____