# Alamitos Dermatological Medical Clinic, Inc.
# (dba: Coastal Dermatology and Plastic Surgery)

**3801 Katella Ave., Ste. 101, Los Alamitos, CA 90720**

## Patient

Social Security Number: _____

Patient Last Name:_____ First Name:_____ MI:_____ Title:_____ Birthdate:_____ Age:_____

Street:_____ City:_____ St:_____ Zip:_____

Hm Phone:_____ Cell Ph:_____ Sex:_____ Marital:_____ Driver Lic:_____

Employer:_____ Occupation:_____ Work Ph:_____ Ext._____

Email:_____ Alt Phone:_____ Spouse_____

## Responsible Party

Patient's Relationship to Insured:_____ SS# of Insured:_____ Hm Ph:_____

Insured's Last Name:_____ First Name:_____ MI:_____ Title:_____ Birthdate:_____

Insured's Street:_____ City:_____ St:_____ Zip:_____ Cell Ph:_____

## Nearest Relative Outside of Home

Name:_____ Relationship:_____ Hm Phone:_____ Cell Ph:_____

Address:_____ City:_____ State:_____ Zip:_____ Wk Ph:_____

## Primary Insurance

Insurance Carrier:_____ Eligible From:_____ ID#:_____ Group#:_____

## Secondary Insurance

Insurance Carrier:_____ Eligible From:_____ ID#:_____ Group#:_____

## Secondary Insured

Patient's Relationship:_____ Insured's Last Name:_____ First Name:_____ MI:_____

## Supplemental Insurance

Insurance Carrier:_____ Eligible From:_____ ID#:_____ Group#:_____

## Patient's Extra Information

Any **ALLERGIES** to Medications? (If so, please list all):_____

Are You a **STUDENT**? (If so, please provide a copy of your student ID): Yes____ No_____

Who **REFERRED** You or How Did You Find Us?: PPO Directory___ Yellow Pgs/Ad (which one)_____
Referring Dr. (Name)_____ Relative (Name)_____ Friend (Name)_____

## Authorization to Release Information and Assignment of Benefit

I hereby assign all medical, and or surgical benefits, for insurance to Alamitos Dermatological Medical Clinic, Inc. A photocopy of this assignment is to be considered as valid as the original. I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize said assignee to release all necessary information to secure payment. **Please remember all balances over 90 days old will be subject to a 1.5% monthly surcharge.**

Print Name:_____ Signature:_____ Date:_____