



# Fine Skin

Rejuvenate Yourself

Dr. Renuka H. Bhatt M.D.

## Patient's Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widow Sex:  Male  Female

Social Sec.: \_\_\_\_\_ Birthday: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency: \_\_\_\_\_ Emergency: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Referral Doctor: \_\_\_\_\_

## Primary Insurance Coverage

Company: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Co-Payment Amount: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Employer: \_\_\_\_\_

## Secondary Insurance Coverage

Company: \_\_\_\_\_

Insured Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ DOB: \_\_\_\_\_

Co-Payment Amount: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Group Number: \_\_\_\_\_

Employer: \_\_\_\_\_



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## Guarantor Information

Guarantor: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Miscellaneous: \_\_\_\_\_

## Patient's Authorization

I authorize FineSkin, Dr. Renuka H. Bhatt to apply for benefits on my behalf for services rendered by FineSkin. I request payment from my insurance company be made directly to FineSkin, Dr. Renuka Bhatt. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when a statement is rendered.

\_\_\_\_\_  
Signature of Subscriber or Beneficiary

\_\_\_\_\_  
Date