



Amber Robbins, M.D., F.A.A.D.

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Patient Legal Name: _____
Last First M.I.

Previous Name: _____ Nickname: _____

Date of Birth: ___/___/___ SSN: _____

Marital Status: S M W D Sex: M F

Mailing Address: _____
City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail: _____

Employer Name: _____ Occupation: _____

Parent, Spouse, or Responsible Party (if different from patient)

Name: _____ Date of Birth: ___/___/___

SSN: _____ Contact Phone: _____

Address: _____
City State Zip

Insurance Information

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

Payment Policy

You will be responsible for paying your annual deductible, co-payment and charges for any non-covered cosmetic services at the time of service. If you do not have medical insurance, payment is expected at the time of service unless other payment arrangements are made in advance.

My signature acknowledges the release of information necessary to process the insurance claims and by signing below, I hereby acknowledge receipt of Notice of Privacy Practice of Robbins Dermatology, P.C.

Signature _____ Date ___/___/___

Please provide your insurance card(s) and driver's license to the receptionist along with this form.