

Robin Berger MD, PC
Diplomate of the American Board of Dermatology
 640 East 700 South
 Suite 1
 St. George, UT 84770



Patient Information Form

Print Name	Last	First	Middle Name or Initial	Nickname/Goes By	Male <input type="checkbox"/> Female <input type="checkbox"/>
------------	------	-------	------------------------	------------------	---

Social Security#	Date of Birth	Month	Day	Year
------------------	---------------	-------	-----	------

Mailing Address	Apt. #
-----------------	--------

City	State	Zip
------	-------	-----

Home Phone	Work Phone	Cell
------------	------------	------

Responsible Party

Physical Address	Apt. #
------------------	--------

City	State	Zip
------	-------	-----

*Self Pay <input type="checkbox"/> Insurance <input type="checkbox"/>	If you would like us to submit forms to your insurance company please provide the following and give your insurance card (s) to the front desk to make a copy for our files. You still need to bring your card with you.
---	--

Primary Insurance	Group Number	Policy Number
-------------------	--------------	---------------

Cardholders Name	Date of Birth	Month	Day	Year
------------------	---------------	-------	-----	------

Secondary Insurance	Group Number	Policy Number
---------------------	--------------	---------------

Cardholders Name	Date of Birth	Month	Day	Year
------------------	---------------	-------	-----	------

*Please provide us with your driver's license
 It is also helpful to have a copy of your drivers license for positive photo ID.

Signature _____ Date _____

I understand that payment is due at the time of service. I am responsible for payment of any charges incurred, including any balance not paid by my insurance. I will be responsible for collection cost by a third party, legal fees, interest, and any other cost incurred in the collection of this account. I authorize release of such information as needed to above insurance companies for reimbursement of claims. I authorize the above insurance companies to release payment directly to Robin Berger MD PC. I authorize Dr. Berger to diagnose and treat me.