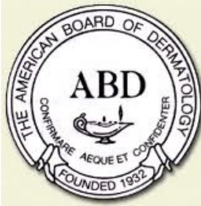


Robin Berger MD PC
Diplomat of the American Board of Dermatology
640 East 700 South, Building 1
Saint George, UT 84770
(435) 673-7546
www.RobinBergerMD.com

Name				
Last	First	Middle	Nickname	Sex

Date of Birth/Social Security Number (SSN not required)			
Month	Day	Year	SSN

Mailing Address			
Street	City	State	Zip

Physical Address Check here if same as Mailing Address ☐			
Street	City	State	Zip

Telephone Numbers		
Home	Work	Mobile

Email Address (Check here for no promotions or informational emails ☐)

Primary Insurance (Check here for Self Pay ☐)		
Company	Group Number	Policy Number

Insurance Cardholder Information			
Full Name	Birth Month	Day of Birth	Birth Year

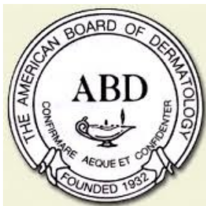
Secondary Insurance (if applicable)		
Company	Group Number	Policy Number

Insurance Cardholder Information			
Full Name	Birth Month	Day of Birth	Birth Year

Signature **Date**

I have been given access to the HIPAA privacy practices notification form.

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 costs by a third party, legal fees, interest and any other costs 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.



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Medications ***(Including over the counter medications and supplements)***
Allergies to Medication
Current Medical Problems
Major Surgeries
Do you use Tobacco Yes ☐ No ☐
Where were you raised ***(Sun exposure as a child)***
Primary Doctor

Authorization to Release Records

You are hereby authorized to release the following information:

□ **Chart Notes**
□ **Pathology/Lab Results**
□ **Billing Records**
□ **Complete Medical Chart (includes all of the above)**

To the following:

____
____

________________________ ____
DATE PRINT NAME

____
SIGNATURE