PATIENT INFORMATION

Patient's last name:	First:	M:	Marital status (circle one) Single / Mar / Div / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age	Sex: ❑ M ❑ F

Street address:	Social Security #:	Cell phone #:

P.O. box:	City:	State:	ZIP Code:

Home phone #:	Email address:	Preferred Contact: ❑ Cell ❑ Text ❑ Home ❑ Email

Primary Care Physician:	Referring Physician (if different):	Physician phone #:

Occupation:	Employer:

How did you hear about our office: ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages
❑ Other:

Can we discuss your medical history with anyone: ❑ Yes ❑ No; if yes, whom:

Can we leave a voice message at your: **home** / **cell** (please circle all that apply)

I hereby grant The Dermatology Center permission to treat my child in my absence: ❑ Yes ❑ No ❑ NA
Parent/Guardian Signature:

INSURANCE INFORMATION

Responsible Party:	Birth date: / /	Address (if different):	Home phone #:

Occupation:	Employer:	Employer address:	Employer phone #:

Name of **primary** insurance:

Subscriber's name:	Subscriber's S.S. #:	Birth date: / /	Group no.:	Policy #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of **secondary** insurance:	Subscriber's name:	Policy #:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other | Subscribers Birth Date: / /

IN CASE OF EMERGENCY

Please Contact:	Relationship to patient:	Home/Work #:	Cell phone #:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I acknowledge my privacy rights and I also authorize **The Dermatology Center** or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*