Dermatology & Advanced Skin Care

Patient Information

Patient's Name (Last, First, Middle)			Date
			Home Phone Number
Address			Work Phone Number/Extension
City	State	Zip	Cell Phone Number
Male ☐ Female ☐	Employed ☐Yes ☐ No	Student ☐Yes ☐ No	E-mail Address
Employer/School Name			Date of Birth / /
Occupation			Patient's Social Security Number
Responsible Party			Responsible Party Phone Number
Billing Address If Different Than Above			
Referred by your physician? ☐Yes ☐No	If Yes, Physician's LAST NAME, FIRST NAME:		
Person to notify in an emergency	Relationship	Phone Number	

Insurance Information

Primary Insurance Carrier	Date Completed:
Group Name or Number	ID #
Address of Insurance Company	City /State/ Zip
Primary Policyholder's Name (Last, First, Middle Initial)	Policy Holder's Date of Birth / /
Policy Holder's Employer	Is insurance through work? Yes ☐ No ☐
What is your relationship to the policyholder? Circle One: I am the: Holder ☐ Wife ☐ Husband ☐ Child ☐	Is a Referral Required? Yes ☐ No ☐

Secondary Insurance Carrier	Date Completed:
Group Name or Number	ID #
Address of Insurance Company	City /State/ Zip
Primary Policyholder's Name (Last, First, Middle Initial)	Policy Holder's Date of Birth / /
Policy Holder's Employer	Is insurance through work? Yes ☐ No ☐
What is your relationship to the policyholder? Circle One: I am the: Holder ☐ Wife ☐ Husband ☐ Child ☐	Is a Referral Required? Yes ☐ No ☐