

NEW PATIENT INFORMATION
PLEASE PRINT

Patient Name _____
Street Address _____
City _____ State _____ Zip Code _____
Billing Address if other than above _____
Date of Birth _____ Age _____ Sex _____ Last 4 Digits of SS# _____
Single Married Widowed Divorced Separated Child
Home Phone (_____) _____ Cell (_____) _____ Email _____
Employer _____ Work Phone (_____) _____
Employer's Address _____
Referred By _____
Do you want a letter sent to your referring doctor? Yes _____ Physician's Name _____ No _____

Please Complete For "Spouse" Or "Parent" / "Guardian" Information

Name _____ SS# _____
Street Address _____
Mailing Address _____
Home Phone (_____) _____ Work (_____) _____ Cell (_____) _____
Employer _____
Employer's Address _____
Next of Kin _____ Add. _____ Phone _____

Primary Insurance To File

Insurance Company Name _____
Insurance Company Address _____
Policy # _____ Group # _____
Insured's Name _____ DOB _____ Relationship to Patient _____
Insured's Social Security # or ID # _____

Secondary Insurance To File

Insurance Company Name _____
Insurance Company Address _____
Policy # _____ Group # _____
Insured's Name _____ DOB _____ Relationship to Patient _____
Insured's Social Security # or ID # _____

Method of Payment Check Cash Visa/MC

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician.

Patient, Parent or Auth. Rep. Signature _____ Date _____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. PAYMENT REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED. We accept payment in the form of cash, check or credit card. We only file insurance for plans with which we have an agreement. You are responsible for any deductible, co-payment or co-insurance amount or any cosmetic procedures. Your signature below signifies your understanding and willingness to comply with this policy.

Patient, Parent or Auth. Rep. Signature _____ Date _____

PLEASE TURN OVER TO COMPLETE

MEDICAL INFORMATION

PLEASE PRINT

Reason for visit: _____

Have you ever had skin cancer _____ Date & Body Area _____

precancer _____ Date & Body Area _____

abnormal mole _____ Date & Body Area _____

Medications you take: _____

(Including birth control pills, vitamins, herbal supplements, over-the-counter medications)

Are you allergic to any medications? List _____

Are you allergic to Latex or Adhesive? _____ If female, are you pregnant? _____

Have you ever had any of the following Medical Problems (current or in the past):

Asthma Diabetes Ulcers Tuberculosis Hay Fever Hepatitis HIV

High Blood Pressure Heart Problems Lung Problems Arthritis

Pacemaker/Defibrillator Liver Problems Kidney Problems Thyroid Problems

Blood Problems Cancer Stroke Seizures Other

Please explain any marked above _____

Do you smoke? Yes _____ No _____ If yes, how often? _____

Do you drink alcohol? Yes _____ No _____ If yes, how often? _____

What type of work do you do? _____

Have any of your relatives had skin cancer? _____