ADVANCED DERMATOLOGY & COSMETIC CENTER

GENERAL INFORMATION

Patient's Name (First, Middle, Last): _____

Address: _____

_____

_____

E-mail Address: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Ext. _____

Where should we call you first, and can we leave a message? _____

Birth Date: _____ Age: _____ Sex: **M** **F**

Social Security #: _____ Ethnicity/Race: _____

Marital Status: _____ Spouse Name: _____

Occupation: _____ Employer/School: _____

If patient is under 18, who is the legal parent/guardian? _____

If applicable, who has Power of Attorney? _____

REFERRING PHYSICIAN

Physician Name: _____

Specialty: _____

Phone #: _____

Fax #: _____

Would you like us to send a letter to this doctor? **YES** **NO**

PREFERRED PHARMACY

Pharmacy Name: _____

Location: _____

Phone #: _____

Fax #: _____

EMERGENCY CONTACT

Emergency Contact Name: _____

Relationship to Patient: _____ Phone #: _____

INSURANCE INFORMATION

*****BRING ALL INSURANCE CARDS INCLUDING PHARMACY CARDS TO EACH APPOINTMENT*****

*****IF YOU DO NOT HAVE A VALID MEDICARE INSURANCE CARD AT THE TIME OF THE APPOINTMENT YOU MUST PAY THE ENTIRE COST IN FULL AT THE TIME OF THE VISIT*****

***** WE WILL DIRECTLY BILL ONE PRIMARY INSURANCE FOR THE VISIT ONLY*****

Name of Insured: _____ Birth Date: _____

Relationship to Patient: _____ Social Security #: _____

Phone Number: _____

How did you hear about us? _____

Signature: _____ **Date:** _____