Anderson and Rahman
DERMATOLOGY

Pt #: _____
(Internal use only)

PATIENT INFORMATION

Social security #: _____

First Name: _____ MI: _____

Last Name: _____

Sex: _____ Date of Birth: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Primary Phone #: (_____)_____

Cell Phone #: (_____)_____

Email Address: _____

Marital Status *(circle one)*: Single Married Divorced Widowed

Race/Ethnicity: Asian Native American White
Black/African American Hispanic/Latino
Non-Hispanic/Latino Other

Language: English Spanish Other

Employment: Full-time Part-time Retired Student Other

Employer: _____

Primary Care Physician: _____

Referring Physician: _____

How did you hear about us? _____

PRIMARY INSURANCE

Card Holder's Name: _____ Date of Birth: _____

Relationship: _____ Employer: _____

SECONDARY INSURANCE

Card Holder's Name: _____ Date of Birth: _____

Relationship: _____ Employer: _____

EMERGENCY CONTACT

First Name: _____ MI: _____ Last Name: _____

Relationship: _____ Date of Birth: _____ Phone #: (_____)_____

GUARANTOR INFORMATION

(If patient is disabled or a minor)

First Name: _____ MI: _____ Last Name: _____

Relationship: _____ Phone#: (_____)_____

Social Security #: _____ Sex: _____ Date of Birth: _____

RELEASE (Signature Required)

Authorization to release information and pay benefits to physician: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the physician or the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, responsible to pay non-covered services.

X_____ _____

Patient Signature (parent signature if minor) *Date*