

ALLURE DERMATOLOGY

Patient Information Form

Today's Date _____

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name (<i>Last, First, MI</i>) / /		Address (<i>Street, City, State, Zip</i>) / / /	
Home Telephone () -	Relation to Insured () 0-Same () 1-Spouse () 2-Child () 3-Other	Date of Birth	Patient's Sex () Male () Female
Cell Phone () -	Pharmacy Name		Pharmacy Phone Number () -
If Patient a Minor - Guardian/Parent Name		Date of Birth	
Patient's Status () 1-Married () 2-Single () 4-Other () 5-Widowed () 6-Separated () 7-Divorced	Social Security #	Prim. Care Physician (<i>Last, First, MI</i>) Telephone /	
Employment Status () 1-Emp FT () 2-Emp PT () 3-Retired () 4-Not Emp () 5-Studnt FT () 6-Studnt PT	Summer Residence Address City State Zip		Summer Residence Telephone () -
Patient's Employer	Employer's Address City State Zip		Employer's Telephone () -
Nearest relative/friend not living with you	Address City State Zip		Telephone Number () -

INSURANCE INFORMATION

Primary Insurance Name	Address City State Zip	Insurance Telephone () -
Policyholder's Name / Relationship to Pt.	Policyholder's Birth Date & Sex / M F CIRCLE ONE	Policyholder's Social Security #
Policyholder's Employer	Employer's Address City State Zip	Employer's Telephone () -
Insured's ID Number	Group Number	Effective Date / Co-Pay /
Secondary Insurance Name	Address City State Zip	Insurance Telephone () -
Policyholder's Name / Relationship to Pt.	Policyholder's Birth Date & Sex / M F CIRCLE ONE	Policyholder's Social Security #
Insured's ID Number	Group Number	Effective Date / Co-Pay /

RELEASE INFORMATION

- I hereby assign my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any non-covered services. I also authorize the physician to release any information required to process this claim.
- I give permission to any representative of this organization to telephone me at my home or my work place with pertinent information and/or to mail personal health information.
- I give my permission to any representative of this organization to give any medical information regarding myself to my (circle all applicable) SPOUSE PARENT SON/DAUGHTER FRIEND RELATIVE. Indicate the name of the person(s) you authorize to receive this information.

SIGNED: _____ DATE: _____