



# Welcome To Our Office

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone 1: \_\_\_\_\_  cell  home  work Phone 2: \_\_\_\_\_  cell  home  work

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Email Address: \_\_\_\_\_ Permission to Send Newsletter/Information  Yes  No

Spouse: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

### RESPONSIBLE PARTY: (Person who should receive the bill)

Relationship to Responsible Party  Self  Spouse  Son  Daughter  Other

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Employer: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

REFERRING PHYSICIAN NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

PRIMARY CARE NAME (PCP): \_\_\_\_\_ PHONE: \_\_\_\_\_

### NOTIFY IN EMERGENCY: (NOT LIVING WITH YOU)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**CONSENT FOR TEST RESULTS:** I give AboutSkin Dermatology & Aesthetics permission to leave all X-rays, lab results, test results, and other medical information and advice on: (check all that apply)

- Voicemail on phone  Answering machine at home  Do not leave message

I authorize the release of any medical information and payment of medical benefits to the undersigned physician or supplier for services necessary to process a claim. I agree to be responsible for any deductible, co-insurance, co-pay, or any other balance not paid by my insurance.

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: (check one)  Self  Parent  Guardian