

ALLERGIES: _____

PATIENT NAME: _____ DOB: _____ AGE _____

WHERE DID YOU HEAR ABOUT OUR OFFICE: _____

LOCAL ADDRESS: _____

HOME PHONE () _____ CELL () _____ WORK # () _____

OUT OF TOWN ADDRESS: _____ OUT OF TOWN PHONE # () _____

MARITAL STATUS ___S___M___W___D___SEP___ SPOUSE NAME _____

SOCIAL SECURITY # _____ STILL WORKING? Yes ___ No ___ STUDENT? Yes ___ No ___

EMPLOYER _____

EMPLOYER'S ADDRESS: _____ PHONE NO. () _____
Street City State Zip

EMAIL: _____ @ _____

IN CASE OF EMERGENCY CONTACT: _____ PHONE # () _____ RELATIONSHIP _____

PERSON RESPONSIBLE FOR PAYMENT, IF NOT YOURSELF? _____

THEIR ADDRESS: _____ THEIR PHONE: _____

PRIMARY CARE DR: _____ Referred by: _____ ?

PHARMACY NAME AND PH # _____ () _____

NON-MEDICARE PATIENTS

INSURANCE CO _____ GRP _____ ID _____ PRIMARY INSURED _____

ADDRESS: _____ PHONE _____

INSURED'S RESPONSIBILITY: It is understood that services rendered by the doctor and this practice are to ME, not to the insurance company, and that the patient and the undersigned are responsible for the payment of such services. All services rendered to me are charged directly to me and I am personally responsible for payment. All "Insufficient Funds" checks are subject to a \$30 service charge. If it is necessary for Martin Dermatology to employ anyone, including attorneys, to collect any payments whatsoever, then I agree to pay all reasonably associated fees and costs including reasonable attorneys fees and costs.

SIGN: PATIENT SIGNATURE (LEGAL GUARDIAN)

DATE