Skin Center of South Miami

PATIENT INFORMATION

How did you learn about our office? ____

DATE: ________________SOCIAL SECURITY #________________________________

NAME: ____
First Middle Last

LOCAL ADDRESS: ____
City: _____________________ State: ________________ Zip Code: _________________
PERMANENT ADDRESS: ____
City: _____________________ State: ________________ Zip Code: _________________
PHONE
Home: (_____)_____________ Work: (_____)____________ Cell: (____)______________
Okay to leave results on recorded message or with answering party? ❑ Yes ❑ No
Age: ___ Birthdate: _____________ Sex: M__ F__ Marital Status:_________________
E-Mail Address: _______________________
Occupation: ____________________ Employed By: _______________________________
Emergency Contact Name:_______________________________Phone: _______________
Relationship: ____

INSURANCE INFORMATION

Do you have Medical Insurance? Yes___ No___
Primary Insurance Co: ____
Name of Insured: ____________________________________ SSN____________________
Your Relationship to Insured: _________________ Birthdate of Insured: ___________
Insured Employer: ________________________________ Phone: ______________
Group #: ________________________Group Name: ______________________________

Secondary Insurance Co: ____
Name of Insured: ____________________________________SSN____________________
Your Relationship to Insured: _________________ Birthdate of Insured: ___________
Group #: ________________________Group Name: ______________________________

MISC. INFORMATION

Primary Care Physician:
Name: _______________________________________ Phone: _____________________

For Office Use Only
ACCOUNT #: ________________ ENTERED BY: __________________DATE: ________________