PATIENT NAME____ DATE OF BIRTH__________________

LAST 4 DIGITS OF SOCIAL SECURITY #___________________ GENDER: Male_____ Female_____

MARITAL STATUS: Single____ Married____ Divorced____ Separated_____

Widowed____ Domestic Partner____ Common Law__

ADDRESS____

CITY / TOWN__________________________ STATE_______________ ZIP CODE________________

HOME PHONE________________ WORK PHONE__________________ CELL PHONE__________________

Which is your preferred phone? Home_________ Work________ Cell________

Is it ok to leave a detailed message? Yes___ No____ E-mail____________________________________

PRIMARY DOCTOR______________________ STUDENT STATUS F/T____ P/T____

EMPLOYER____ F/T____P/T____

What pharmacy do you prefer to use for prescriptions? __________________________ Location__________________

____

PER FEDERAL REGULATIONS, WE ARE <u>REQUIRED</u> TO OBTAIN THE FOLLOWING INFORMATION:

*WHAT IS YOUR PREFERRED LANGUAGE? __________________________________

*ETHNIC GROUP: Hispanic or Latino____ Non-Hispanic or Non-Latino_____ Unknown____

*RACE: White____ Black or African American____ Asian____ Native American_____

____

Spouse/Partner____________________________ If patient under 18, Parent Name__________________________

Spouse/Partner Cell #_______________________ Parent Cell #___________________________________

Spouse/Partner Employer___________________________ Parent Employer_______________________________

--OVER—

RELEASE OF INFORMATION

I, ______________________________, give Barrington Park Dermatological Associates, P.C. my permission to
(Patient Name)
release biopsy results, blood work results and any medical information to the following person(s) on my behalf:

Name:	Relationship:	Contact Number:
______________________________	______________________	____________________
______________________________	______________________	____________________
______________________________	______________________	____________________

INSURANCE INFORMATION

Primary Insurance__________________________

ID #______________________________________

Subscriber Name___________________________

Subscriber DOB____________________________

Subscriber Address (if different from patient)

____

____

Subscriber's Employer_______________________

____

Secondary Insurance__________________________

ID #______________________________________

Subscriber Name___________________________

Subscriber DOB____________________________

Subscriber Address (if different from patient)

____

____

Subscriber's Employer_______________________

____

BILLING INFORMATION

Name ____ DOB__________________________

Address____

Phone________________ E-mail____

Employer______________________________________ Employer phone #_____________________