PERRI SKIN CARE / SURGICAL SPECIATIES

Patient Information Form

Name: ____ **(Please Circle)** Mr. Mrs. Ms. Miss. Dr.
(First) (Middle Initial) (Last)

Home Address:_______________________________**City**:________________**State**:______**Zip Code**: _______

SS #:______-______-______ **Marital Status:** _________ **DOB:** ______/______/______ **Gender:** Male / Female

Race: ____________ **Ethnicity:** Hispanic or Latino / non-Hispanic or Latino **Primary Language:** ________________ **Declined**

Home #: (________)________________ **Mobile #:** (________)______________ **Work #:** (________)______________

Please circle contact preference: Home / Mobile / Work

E-Mail Address: _______________________________ **Is it ok to contact you by e-mail:** Yes / No

Emergency Contact

Name:________________________ **Relationship**:_______________ **Phone #:** (_________)______________

Please sign below ONLY if you give permission for our providers/staff permission to discuss your medical and/or financial information with the person listed above:

X____ _________

Patient/responsible party signature Date

Pharmacy Name: _______________ **Address:** _____________________ **Phone#:** (________)_______________

Employment Status: ______________ **Employer:** _________________**Occupation:** ______________________

How did you hear about us? ____

Family Doctor: ________________________________ **Date of Last Visit:** Month ___________ Year ___________

Address: ____ **Phone:** (________)_________________

Billing Information *(If your insurance is a part of **ObamaCare** or **Medicaid** please notify us prior to continuing)*

Primary Insurance:______________________ ID#:________________________**Requires Referrals?** Y/N
Subscriber Name: ____________________ DOB: _____________ SS#______-_____-______ Relation: _____________

Secondary Insurance:____________________ ID#:________________________**Requires Referrals?** Y/N
Subscriber Name: ____________________ DOB: _____________ SS#______-_____-______ Relation: _____________

Medications:

Please list all medications (or provide list on separate piece of paper). Please include over the counter medications.

Name & Strength	Frequency (How often do you take it?)	Who Prescribed it?

Allergies: Please list all allergies to medications or circle No Known Drug Allergies

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