Today's Date: _____

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.

_____

_____

_____

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

_____