PATIENT INFORMATION (Please print)

Last Name:_____ First Name: _____ MI: _____

Address:_____ Apt:_____ City:_____ State_____ Zip_____

Date of Birth_____ Age_____ Male_ Female _

Home Telephone: (_____)_____ Cell Phone (_____)_____ Social Security Number : _____
(Protected by HIPPA Privacy Act)

Single _ Married _ Widowed _ Divorced _ Drivers License/ID#:_____ State _____

Employer: _____ F/T _ P/T _ Unemployed _ Work Phone:(____)_____

Occupation: _____ Employer Address: _____

Email Address: _____ May we communicate with you via e-mail
(We will never share your email address with anyone)

How were you referred to this office?_____

Have you ever seen another physician for this problem? Yes _ No_ If yes, name: _____

INSURANCE INFORMATION

Please give your insurance card to the receptionist.

GUARANTOR/INSURED INFORMATION: If you are **NOT** the policyholder, please provide the following:

Policyholder's name: _____ Male _ Female _ Date of Birth _____

Policyholder's address: _____ Patient's relationship to policyholder: _____

Policyholder's Social Security number: _____ (Protected by HIPPA Privacy Act)

Employer: _____ Employer address: _____

EMERGENCY

Name:_____ Relationship to patient: _____

Home telephone: (_____)_____ Work telephone: (_____)_____

Do we have your permission to:

1. Leave messages on your answering machine regarding confidential biopsy/lab results?
   Yes ð No ð If yes, please note preferred phone number: (_____)_____
2. Discuss your medical condition with any member of your household? Yes _ No_
   If yes, whom: _____ Relationship: _____

ACKNOWLEDGEMENT OF RECEIPT

I hereby acknowledge that I have received a copy of Manhattan Beach Dermatology's Notice of Privacy Practices.

Signature **X** _____ Date_____

All patients under the age of 18 must be accompanied by a parent or legal guardian.

All the above information is true to the best of my knowledge.

Signature **X**_____ Date _____

Patient signature / Parent or legal guardian of minor