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DAVIE DERMATOLOGY, P.A.
AT KINDERTON

Date _____

PATIENT INTRODUCTION

Patient's Name _____
Last First Middle Age _____

Address _____

No. and Street City State Zip

Birth Date Sex Home Phone # Cell #

Employer's Name _____

Employer's Address _____

Employer's Phone # Your Social Security #

Who referred you to our office? _____

Who is your family doctor? _____

Marital Status: Single Married Other _____

Spouse's Name/Parent if under 18 Spouse's Date of Birth

Spouse's Employer/Parent's if under 18 _____

Notify in Case of Emergency _____

Phone Number () Relationship

INSURANCE INFORMATION

Primary Insurance Company _____

ID # Group #

Policy Holder's Name Insured's Date of Birth

Secondary Insurance Company _____

ID # Group #

Policy Holder's Name _____

I hereby authorize payment directly to Davie Dermatology, P.A. of the surgical and/or medical benefits. I hereby authorize Davie Dermatology, P.A. to release any information acquired in the course of my examination and/or treatment to my insurance carriers, third party payers or others directly involved in processing and collection of any claims submitted on my behalf.

Signature: _____

DO WE HAVE YOUR PERMISSION TO:

Leave a message on your answering machine at home? Yes No

Leave a message at your place of employment? Yes No

Discuss your medical condition with any member of your household? Yes No

If yes, whom? Relationship

Patient Signature Date