

BRIGHTON DERMATOLOGY CENTER

Patient Information

(Please print clearly in BLACK INK only)

Today's Date:

Legal Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Sex: M F Social Security # \_\_\_\_\_ Marital Status: S M W D

Patient's Employer \_\_\_\_\_ Employer Phone (\_\_\_\_) \_\_\_\_\_

Employer's Address \_\_\_\_\_

E-Mail Address \_\_\_\_\_ [ ] I agree to accept e-mails from Brighton Dermatology

How did you hear about us (ex: phone book, signage, insurance co, another patient)? \_\_\_\_\_

Or Name of Physician referred by: \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Spouse's Social Security # \_\_\_\_\_

**IF PATIENT IS UNDER 18, OR INSURANCE IS IN PARENT'S NAME, PLEASE FILL OUT PARENT INFORMATION**

Father or Guardian

Mother or Guardian

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Employer's Phone:(\_\_\_\_) \_\_\_\_\_ Birthdate: \_\_\_\_\_

Employer's Phone: (\_\_\_\_) \_\_\_\_\_ Birthdate: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Social Security #:

Social Security #:

IN CASE OF EMERGENCY, please give name, address and phone number of a friend or a relative not living at your address:

Name: \_\_\_\_\_

Relation to you: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_ Address: \_\_\_\_\_

IF YOU ARE 18 OR OLDER, WE ARE UNABLE TO DISCUSS YOUR MEDICAL CONDITION WITH OTHER INDIVIDUALS IN YOUR FAMILY WITHOUT YOUR PERMISSION. DO YOU GIVE US PERMISSION TO DISCUSS YOUR CONFIDENTIAL MEDICAL INFORMATION WITH SOMEONE OTHER THAN YOURSELF? \_\_\_YES or \_\_\_NO

If yes, Name of Person: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

I hereby authorize my insurance benefits to be paid directly to the above signed physician, realizing I am responsible to pay non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Insured: \_\_\_\_\_ Today's Date: \_\_\_\_\_