NAME____ **MY PREFERRED NAME** ________________
First Middle Last

ADDRESS____ **AGE**________
Street Apt #

____ **HOME PHONE** ______________________
City State Zip Area Code number

CELL PHONE______________________ **SEX** Male / Female **MARITAL STATUS** S M W D
Area code number

SOCIAL SECURITY NUMBER______________________ **DATE OF BIRTH**_____/______/_______
Month Day Year

REFERRED BY ANOTHER PHYSICIAN? (NAME)____

EMPLOYER____
Name City/State phone number

SPOUSE__________________________________ **SPOUSE DATE OF BIRTH** _____/______/______
Month Day Year

SPOUSE'S EMPLOYER____
Phone number

EMERGENCY CONTACT____
Name phone number

PLEASE PRESENT INSURANCE CARDS OR OTHER DOCUMENTS TO RECEPTIONIST FOR COPYING

NAME OF POLICY HOLDER (If other than patient**)** ______________________________________

RELATIONSHIP TO POLICYHOLDER Self / Spouse / Child **POLICYHOLDER DATE OF BIRTH**______________

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE FOR "YOUR PART" OF THE CHARGES. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims. You authorize payment of medical benefits to the Doctor when an assigned claim is filed.

** ____ __________________
Signature of patient or legal guardian Date

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:________________

I HAVE REVIEWED AUBURN DERMATOLOGY'S HIPAA NOTICE OF PRIVACY PRACTICES.

** ________________________________ _______________________
Patient Signature Date