DAVIS DERMATOLOGY **(530) 756-5758**

Patient Information as of _____ (enter today's date)

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name _____

First Middle Last

Address _____

Street & Apt # City State Zip

Home Phone _____ Cell Phone _____ Other Phone _____

Any restrictions for contacting you? ❒ No ❒ Yes E-mail _____

Contact Restrictions: _____

Age _____ Birthdate _____ SS# _____ Gender ❒ Female ❒ Male

Marital Status ❒ Single ❒ Married to: _____ ❒ Other: _____

Patient's Employer _____ Occupation _____

Work Phone _____ Ext: _____ Is it okay to call you at work? ❒ Yes ❒ No

Address _____

Street & Suite # City State Zip

How did you hear about ? (Mark all that apply)

❒ TV News ❒ TV Ad ❒ Phone Book ❒ Magazine ❒ Newsletter ❒ Seminar ❒ Salon ❒ Web ❒ Friend/Relative: _____ ❒ Doctor: _____ ❒ Other: _____

Please list your pharmacy of choice _____

Emergency Contact (Not in your household) _____ Relationship to Patient _____

Home Phone _____ Work Phone _____ Other Phone _____

Primary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Insured:
Name _____ DOB _____ Employer _____

Secondary Health Insurance Company _____

Policy # _____ Group # _____ Ins. Phone _____

Referral Required? ❒ No ❒ Yes Copay? ❒ No ❒ Yes, $ _____

Insured:
Name _____ DOB _____ Employer _____

I understand that office visit charges are payable on the day service is rendered. I authorize to bill my insurance company for medically necessary services. I understand that I am financially responsible for all procedures considered **not medically** necessary by my insurance company policy. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between and myself.

Signature _____ **Date** _____

Would you like a complimentary skin evaluation while you are here today? ❒ Yes ❒ No