Patient Information

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

Patient's Name: (First)_____(MI)_____(Last)_____

Address:_____City:_____State:_____Zip:_____

Phone (H):_____Phone (W):_____Phone (C):_____(please check preferred)

E-Mail Address:_____

Birth date:_____ Age:_____Gender: r Female r Male

Social Security #_____Drivers license number (if a minor, please use guarantor)_____State_____

Marital Status: r Married to:_____ r Single r Divorced r Widow

Patient's Employer _____ Occupation _____

Work Phone:_____Ext_____ Is it okay to call you at work? r Yes r No

Address:_____City:_____State:_____Zip:_____

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

r TV Ad rRadio r Newspaper r Phone Book r City Arena r Newsletter r Seminar r Salon rWeb r Other

r Friend/Relative: _____ r Current patient _____ r Doctor:_____

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

rHome phone_____ rWork Phone_____rCell Phone_____(please check preferred)

rEmail address:_____

Parent/Guarantor Information: If the patient is a minor, please complete the following information

Parent/Guardian Name:_____Relationship to patient_____

Address: _____City:_____State:_____Zip:_____

Home Phone:_____Work Phone:_____Cell Phone_____SS#_____

Preferred method of contact: r Home r Work r Cell May we leave a message regarding appointments? r Y r N Regarding your care? r Y r N

Referred by Dr. _____Phone:_____

Referring physician's address:_____City:_____State:_____Zip:_____

May we discuss your medical condition with another family member? Y N

If yes, Whom?_____

AUTHORIZATIONS

I authorize medical treatment of the person named above and agree to pay all fees and charges for such treatment. I understand that medical treatment may include a review of medical history, discussion of reason for visit and medical photographs of the area being discussed.

I authorize Zogg Dermatology, PLC to disclose complete information concerning medical finding and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Zogg Dermatology, PLC determination, are required to receive such information for the purpose of medical treatment, medical quality assurance, peer review, and *if applicable* to process the insurance claim for services rendered at Zogg Dermatology, PLC.

Signature _____ **Date** _____