THE MENKES CLINIC
Medical, Surgical and Cosmetic Dermatology

PATIENT INFORMATION

PLEASE PRINT (PLEASE COMPLETE ENTIRE FORM)

Date: _____/_____/_____

Name: _____
LAST FIRST M.I. NICKNAME

Address: _____ Home Phone: (_____)_____
STREET APT #

City: _____ State:_____ Zip: _____ Work/Cell Phone: (_____) _____

Email: _____ Sex: M F Birthdate: _____/_____/_____ Age: _____
CIRCLE ONE

Emergency Contact: _____ Phone #: (_____)_____ Marital Status: M S W D
CIRCLE ONE

HIPPA PATIENT PRIVACY	I authorize The Menkes Clinic to discuss my appointment, financial and medical data with: Name _____ Relationship _____ I authorize The Menkes Clinic to leave personal voice messages on phone #(s): Ph # (_____) _____ Ph # (_____) _____ I request Special Privacy PRotection to restrict health information disclosure (separate form) Y ___ N___

Primary Care Physician: _____ Office Phone: (_____)_____

How were you referred to our office? _____

IF PATIENT IS A MINOR Parents Name _____

Work Phone Father (_____)_____Work Phone Mother (_____)_____

POLICYHOLDER (Member) INSURANCE INFORMATION
PLEASE COMPLETE ALL INSURANCE INFORMATION AND PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST.

Primary Insurance _____ Secondary Insurance _____
COMPLETE ONLY IF APPLICABLE

Subscriber Name: _____ Subscriber Name: _____
NAME OF THE POLICY HOLDER NAME OF THE POLICY HOLDER

Relationship to Subscriber: _____ Relationship to Subscriber: _____

Subscriber's Birthdate: _____/_____/_____ Subscriber's Birthdate: _____/_____/_____