

COASTAL DERMATOLOGY
DERMATOLOGY & DERMATOLOGICAL SURGERY

PLEASE PRINT CLEARLY

DATE: _____

PATIENT **FIRST NAME:** _____ **MI:** _____ **LAST NAME:** _____

BIRTHDATE: _____ **SEX: M F** **MARITAL STATUS: S M D W** **SOCIAL SECURITY#:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME PHONE: _____ **CELL PHONE:** _____ **EMAIL:** _____

EMPLOYER: _____ **WORK PHONE:** _____

IF PATIENT IS A MINOR:

FATHER: _____ **MOTHER:** _____

HOME PHONE: _____ **BIRTHDATE:** _____ **HOME PHONE:** _____ **BIRTHDATE:** _____

EMPLOYER: _____ **EMPLOYER:** _____

WORK PHONE: _____ **WORK PHONE:** _____

REFERRING/PRIMARY CARE PHYSICIAN: _____

HOW DID YOU HEAR ABOUT OUR OFFICE: _____

FRIEND OR RELATIVE FOR EMERGENCY CONTACT:

NAME: _____ **PHONE #:** _____

INSURANCE INFORMATION: PLEASE PRESENT YOUR INSURANCE CARD(S) TO RECEPTIONIST

PRIMARY INSURANCE: _____ **INSURED NAME:** _____

RELATIONSHIP TO INSURED: _____ **DATE OF BIRTH OF INSURED:** _____

SECONDARY INSURANCE: _____ **INSURED NAME:** _____

RELATIONSHIP TO INSURED: _____ **DATE OF BIRTH OF INSURED:** _____

I, THE UNDERSIGNED, AUTHORIZE PAYMENT BY MY INSURANCE COMPANY TO BE MADE DIRECTLY TO ROSS KAPLAN, MD FOR ANY MEDICAL AND/OR SURGICAL BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES PROVIDED. I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NEEDED TO DETERMINE THESE BENEFITS. THIS AUTHORIZATION SHALL REMAIN VALID UNTIL WRITTEN NOTICE IS GIVEN BY ME REVOKING SAID AUTHORIZATION. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY MY INSURANCE. I CONSENT TO PHOTOGRAPHY FOR DIAGNOSTIC USE.

SIGNATURE _____ **DATE** _____

FORM UPDATE _____

FORM UPDATE _____