

SODERSTROM SKIN INSTITUTE PATIENT INFORMATION RECORD
(please print)

Patient Name: _____
FIRST NAME LAST NAME MI

Social Security and/or Medicare No: _____ Birthdate: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Patient's Sex: M F E-mail Address: _____
 Marital Status: Married Single I do not wish to receive educational information, information about upcoming seminars, special events and valuable offers from Soderstrom Skin Institute.
 Separated Divorced

Phone: (____)____-____ (____)____-____ (____)____-____
HOME PHONE WITH AREA CODE WORK PHONE WITH AREA CODE CELL PHONE WITH AREA CODE

Who sent you for a consultation in our office? (circle one)
 Doctor / Nurse / Physician Assistant / Emergency Room / Public Health Dept. / Work Comp. / Nursing Home
 Healthcare Center / Attorney / Insurance Company / Other
Name of Referring Doctor/Provider: _____
NAME CLINIC / CITY

Guarantor: _____ Guarantor Phone: (____)____-____
ADULT ACCOMPANYING MINOR FIRST NAME LAST NAME MI

Address: _____ City: _____ State: _____ Zip: _____

Relationship to Guarantor: _____ Guarantor Date of Birth: ____/____/____

Insurance Information: Patient's Employer: _____

Primary Insurance Name: _____ Policy # _____ Group # _____
 Policy Holder Name: _____ Date of Birth: ____/____/____
LAST FIRST

Secondary Insurance Name: _____ Policy # _____ Group # _____
 Policy Holder Name: _____ Date of Birth: ____/____/____
LAST FIRST

Emergency Contact: _____ (____)____-____
RELATIONSHIP

The following individuals have my permission to access my Protected Health Information (Spouse, Mother, Father, etc):
 _____ (____)____-____ (____)____-____
NAME - FIRST CHOICE (RELATIONSHIP) NAME (RELATIONSHIP)

How did you hear about our office:

1 <input type="checkbox"/> Relative or Friend	4 <input type="checkbox"/> Yellow Pages	7 <input type="checkbox"/> Other/Coupon _____	10 <input type="checkbox"/> Skin Cancer Screening	13 <input type="checkbox"/> Billboard
2 <input type="checkbox"/> Newspaper	5 <input type="checkbox"/> Brochure	8 <input type="checkbox"/> Phone Book	11 <input type="checkbox"/> Television	
3 <input type="checkbox"/> Public Lecture	6 <input type="checkbox"/> Lay Groups	9 <input type="checkbox"/> Radio	12 <input type="checkbox"/> Referring MD	

Did you receive a phone call appointment reminder? Yes No

I have fully completed this form and certify that I am the patient, or adult authorized general agent of this patient, authorized to furnish the information requested and the information is true. Further, I authorize release of any medical information requested by my insurance company or by another physician. I request that payment of insurance benefits be made directly to Soderstrom Skin Institute. I am fully financially responsible for all cosmetic procedures.

I understand my insurance coverage is a contract between myself and my insurance company and I agree to accept financial responsibility for payment of charges incurred. Billing for pathology may be done at the time the lesion(s) was/is removed or later at the time the specimen is read under the microscope. If a second consultation for pathology is required, or special stains are needed, there may be an additional bill from an outside pathologist or lab. In addition, I understand that Soderstrom Skin Institute does not accept insurance company "usual and customary payments" as payment in full and that I am responsible for full payment of any balance, including any necessary additional charges.

DATE _____ PATIENT/RESPONSIBLE PARTY SIGNATURE: X

We are concerned about your privacy and will not sell or lease your personal information to any third party. We will use your personal information for the purpose of sending you educational information, information about upcoming seminars, special events and valuable offers. For full details of our Privacy Policy please visit www.SoderstromSkinInstitute.com.
 I have received the HIPAA Privacy Notice for Soderstrom Skin Institute.

DATE _____ PATIENT/RESPONSIBLE PARTY SIGNATURE: X