LIMMER DERMATOLOGY
Your Skin. Our Specialty.

Entered _____Scanned_____

PATIENT DEMOGRAPHICS

Patient: _____
First Name **Initial** **Last Name**

Sex: ☐ M ☐ F ☐ Single ☐ Married ☐ Other

SS#: _____ **Birth Date:** _____ **Age:** _____

Street Address: _____

City: _____ **State**: _____ **Zip**: _____

Home Phone: _____ **Cell Phone**: _____ **Preferred:** ☐ Cell ☐ Home

Employer:_____

(PLEASE CIRCLE ONE)
Language: English Spanish Other:_____ **Ethnicity:** Hispanic Not Hispanic

Race: African American White Asian American Indian Native Hawaiian Other: _____

Emergency Contact: _____ **Relationship:** _____

Emergency Contact Phone: _____

Preferred Pharmacy: _____ **Phone:** _____

I certify that all information listed above is current and correct.

_____ _____
Signature **Date**

INSURANCE RELEASE

For Medicare Patients Only:
This is required to keep your signature on file, authorizing us to file claims to Medicare for you and to release information that the payer requires for proper consideration of a claim. Please read and sign the following statement:

I authorize the providers at Limmer Dermatology to release to the Social Security Administration or its intermediaries or carriers any information needed for this claim or any related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment.

_____ _____
Signature as on Medicare Card **Date**

If you have an additional policy to Medicare, we are required to keep a separate signature on file.

_____ _____
Signature as on Insurance Card **Date**