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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**

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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**