DERMATOLOGY ASSOCIATES Beth Honl, MD

Patient Name (First/MI/Last) _____ Sex ☐ M ☐ F

DOB:_____ SSN:_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Address_____ City:_____ State:_____ Zip:_____

Phone: Home ( )_____Work ( )_____Cell ( )_____

Employer_____ ☐ Full Time ☐ Part Time ☐ Retired ☐ FT Student ☐ PT Student

Referring Physician:_____How did you hear about us?_____

Name of pharmacy and its location?_____

Please provide the following to receive appointment reminders: (Note: notification will include business name)

Text to Mobile Phone: **Please choose your Mobile Carrier** ☐ **Verizon** ☐**Sprint** ☐**AT&T** ☐**Nextel** ☐**Quest** ☐**T-Mobile** ☐**Virgin Mobile**

Email: _____

Please check the best phone number to reach you: ☐ Home ☐Work ☐ Cell

*Appointment reminders will be sent to you unless you notify us that you decline reminders.

Person responsible for bill if other than the above:

Name:_____Relationship_____

Address_____ City:_____ State:_____ Zip:_____

Phone: Home ( )_____Work ( )_____Cell ( )_____

DOB:_____SSN:_____ Employer_____

Individuals whom you may discuss my medical care with: ☐ You may NOT discuss my care with anyone.

Name _____Relationship:_____Phone: ( ) _____

Name _____Relationship:_____Phone: ( ) _____

Person to notify in case of emergency:

Name_____Relationship:_____Phone: ( )_____

Insurance Information: Copy of card must be filed in record ☐ **Self Pay**

1. **Primary Insurance Company**_____

Group ID_____ Member ID_____

Policy Holder (if other than the patient)_____Relationship_____

Address_____ City_____ State_____ Zip_____

Phone Home ( )_____Work ( )_____Cell ( )_____

DOB_____SSN_____ Employer_____

2. **Secondary Insurance Company**:_____

Group ID_____ Member ID_____

Policy Holder (if other than the patient)_____Relationship_____

Address_____ City:_____ State:_____ Zip:_____

DOB_____SSN_____ Employer_____