Please complete all sections

(Cell)_____
(Work)_____
Phone (Home)_____

NAME OF PATIENT_____
Last Name First Name M.I.

Address_____ Social Sec. #_____ Age____ Date of Birth_____

_____

Race: ☐White
☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Native Hawaiian or Other Pacific Islander
☐Other Race

Ethnic Group : ☐Hispanic or Latino
☐Not Hispanic or Latino
☐Unknown

Preferred Language:_____

Sex: ☐Male ☐Female

Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Sep. ☐Partner

Occupation_____ Employer's Name and Address_____

Employed: ☐Full-time ☐Part-time ☐Retired ☐Active duty military ☐Unemployed

Spouse's Name_____ Spouse's Date of Birth_____ Spouse's Soc. Sec. #_____

Spouse's Employer & Address_____

Name of Person Responsible for Payment_____

Address_____

INSURANCE INFORMATION - Please bring insurance card(s) with you and verify that we participate in your plan(s).

PRIMARY INSURANCE:_____
ID #:_____
Group #:_____
Name of Insured:_____

SECOND INSURANCE:_____
ID #:_____
Group #:_____
Name of Insured:_____

THIRD INSURANCE:_____
ID #:_____
Group #:_____
Name of Insured:_____

MEDICAL INFORMATION

How long has patient had present skin condition?_____ Where located?_____

Patient's height_____ weight_____

Please complete separate
Patient History and Intake Form

Referred by_____ Name of family doctor_____

I hereby authorize Dr. Masters to provide medical treatment to the above-named patient. I also authorize Dr. Masters to release any information acquired in the course of treatment or examination to the appropriate insurance company(ies) or other physicians as needed.

_____ _____
Date Patient's Signature