Please complete all sections
for minor patient

(Cell)____________
(Work-Father)____________
(Work-Mother)____________
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

If patient is age 19 or over: ☐Full-time student ☐Part-time student School________________ Enroll. Dt.________

Father's Name____________________ Father's Date of Birth__________ Father's Soc. Sec #____________

Father's Employer and Work Address____

Mother's Name____________________ Mother's Date of Birth__________ Mother's Soc. Sec #____________

Mother's Employer and Work 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 Parent or Guardian's Signature