SANTA MONICA DERMATOLOGY 2001 Santa Monica Bl. Suite 990W, Santa Monica, CA 90404
All BOLD information below must be filled out for us to process your insurance.

PATIENT REGISTRATION INFORMATION

Date____________________ **Soc. Sec #**_______________________ **DATE OF BIRTH**_______________**Age**________________

Name____
First name Middle Name Last Name

Address____ **Home Phone**____

City____ **State**______________ **Zip**______________________________

Cell Phone____________________________ **Sex**:Male____ Female____ Occupation__________________________________

Employer____ Business Phone_________________________

Business Address____

Marital Status: Minor____ Single____ Married____ Long-term Partner____ Divorced____ Widowed____ Separated____

Spouse's Name__________________________________ Birth date___________________ Soc Sec #__________________________

Spouse's Employer____

Who referred you to our office?____

In case of emergency, who should we contact?__________________________________Phone_____________________________

PRIMARY INSURANCE

Primary insurance company____ **Medicare or ID#**____________________________

Policyholder's Name ____
First Name Middle Name Last Name

Relationship to Patient___________________________ **Birthdate**_________________**Soc. Sec.**___________________________

Insurance Group #_________________________ **Insurance Address**____

Insured Employed by____ **Business Phone**______________________________

SECONDARY INSURANCE (IF APPLICABLE)

Secondary insurance company____ **Medicare or ID#**_______________________

Secondary Insured's Name____
First Name Middle Name Last Name

Relationship to Patient______________________________ **Date of Birth**____________________**Soc. Sec.**___________________

Insurance Group #_______________________ **Insurance Address**____

Insured Employed by____ **Business Phone**______________________________

BILLING ADDRESS (IF DIFFERENT FROM ABOVE)

Name of Responsible Party____ Relationship_______________________________

Address:____
Number and Street City Zip Code

REASON FOR VISIT

Reason for consulting Doctor____

____

Date of onset of condition____