SANTA MONICA DERMATOLOGY 2001 Santa Monica Bl. Suite 990W, Santa Monica, CA 90404

PATIENT REGISTRATION INFORMATION

Date_____ **Soc. Sec #**_____ **Date of Birth**_____ **Age**_____

Name_____
First name Middle Name Last Name

Address_____ **APT #**_____ **Home Phone**_____

City_____ **State**_____ **Zip**_____

Cell Phone_____ **Preferred Appointment Reminder Method: Text / Phone**

Email address:_____ Occupation_____

Patient Gender: Male_____ **Female**_____ **Unspecified**_____ **(For Insurance purposes)**

Employer_____ Business Phone_____

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

Spouse's Name_____ Birth date_____ Soc Sec #_____

Emergency Contact Name_____ 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**_____

******WE MUST HAVE INSURED DATE OF BIRTH AND RELATIONSHIP FOR US TO BILL YOUR INSURANCE**********

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**_____

******WE MUST HAVE INSURED DATE OF BIRTH AND RELATIONSHIP FOR US TO BILL YOUR INSURANCE**********

MEDICAL INFORMATION

Who is your primary physician?_____

Who referred you to our office?_____

Reason for consulting Doctor_____

_____

Date of onset of condition_____

Past medical history_____

_____

Current Medications_____

Allergies_____