PATIENT INFORMATION

DATE_____

Patient's Name_____
Last First Middle Married Single Divorced Widowed

Address_____
Street Apt # City State Zip

Home Phone ( )_____/_____ Social Security#_____/_____/_____/ Cell phone( )_____/_____

Birth Date ____/____/____/ Age_____ Sex (M/F) _____ Driver's License #_____

Employer_____ Work Phone_____ Occupation_____

How were you referred to our office?_____

Who to notify in case of an emergency_____Relationship _____ Phone #_____

INSURANCE INFORMATION

Medicare #_____ Medi-cal #_____

PPO/HMO Subscriber ID#_____ Group Policy # _____

Please complete the following if patient is other than the insured…

Insurance Co Name_____Ins. Co. Phone _____

Insured's Name _____ Insured's Social Security #_____

Insured's date of birth ____/____/____/ Insured's Drivers License#_____

Insured's Employer_____Occupation_____

Address_____
Street City State Zip

Work Phone( )_____/_____ Patient relationship to insured: Spouse_____ Child_____

Authorization of Medical Benefits

I hereby authorize the Insurance Company to pay by check and mail to: DON F. KING M.D./PREFERRED DERMATOLOGY 7947 S. Painter Ave, Whittier, Ca. 90602

PLEASE SIGN ATTACHED CONSENT FORM