Psoriasis & Eczema
TREATMENT CENTER
BY H2|DERMATOLOGY

PATIENT INFORMATION

Name_____ Date of Birth_____Sex: M F Mar. Status_____
Last Name First Name M.I.

Address_____
Street Address City State Zip + four

Home Phone _____ Cell Phone _____ Work Phone_____

Email:_____

Occupation: _____ Employment Status: FT PT NONE Student Status: FT PT NONE

RESPONSIBLE PARTY: (if patient is a minor)

Name _____ Home Phone_____ Cell Phone_____

Address_____
Street Address City State Zip + four

PRIMARY INSURANCE

Subscriber Name: _____ Subscriber Birthdate _____

Group#_____ Insured's ID#_____ Relation to Subscriber_____

Employer Name_____ City_____

SECOND INSURANCE

Subscriber Name: _____ Subscriber Birthdate _____

Group#_____ Insured's ID#_____ Relation to Subscriber_____

In case of Emergency , who should be notified: _____ Phone_____

Pharmacy of Choice: _____ Phone_____

Primary Care Physician _____ Did they refer you? Yes No

Release of Medical/Financial information- You must give us permission to talk with others about your medical care or billing information. Unless their name is listed below, we may not speak to them about your care or your bill. Please indicate your emergency contact.

_____ Medical Billing ER contact
Name Relationship Phone number

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Name Relationship Phone number