PATIENT INFORMATION
MCLAUGHLIN DERMATOLOGY
JENNIFER A. MCLAUGHLIN, M.D., CHRISTY HOLMAN, PA-C

Acct #_____
For Office Use

Name of Patient_____ Date_____

Social Security Number _____

Address_____ **Birth Date**_____

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

Home Phone_____ **Work Phone** _____ **Cell #**_____ **E-mail Address**_____

Marital Status ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated **Sex**_____ **Age**_____

Occupation_____ Employer's Name and Address_____

Family Doctor_____ Address_____

Referred by_____ Address_____

Has any correspondence been forwarded to us by your doctor?_____ Have you been seen in this office prior to today?_____

Reason for visit_____

Drug Allergies_____

Person to contact in case of emergency_____ Phone_____

INSURED SUBSCRIBER INFORMATION

Name:_____ SS#_____ DOB:_____

Home Phone:_____ Work Phone:_____ Mobile:_____

Employer:_____ Relationship to Patient:_____

Complete this section only if Patient is a Minor:

Mother's Name_____ DOB_____ Father's Name_____ DOB_____

Address:_____ Address:_____

Home Phone:_____ Home Phone:_____

SS#_____ SS#_____

Employer:_____ Employer:_____

Address:_____ Phone:_____ Address:_____ Phone:_____

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE

I, the undersigned, authorize payment of medical benefits to MCLAUGHLIN DERMATOLOGY, for any services furnished to me by the physicians. I understand that I am financially responsible for any amount not covered by my insurance contract. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purposes of evaluating and administering claims of benefits.

Date_____ Signature of Patient or Guardian_____ Relationship_____

MEDICARE LIFETIME SIGNATURE ON FILE

I request the payment of authorized Medicare benefits be made either to me or on my behalf to MCLAUGHLIN DERMATOLOGY, for any services furnished me by physicians. I authorize any holder of medical information about me to release to The Health Care Financing Administration and its agents any information needed to determine these benefits payable to related service.

Date_____ Signature of Patient or Guardian_____ Relationship_____