PRECISION SKIN CARE

Patient Demographics Form

Name_____ Preferred Name_____
FIRST MIDDLE LAST

Date of Birth_____ Social Security Number_____ Age____ Sex_____
MONTH DAY YEAR

Home Mailing Address_____
STREET CITY STATE ZIP

Home Phone_____ Cell Phone_____ Work Phone_____

May we leave a voicemail? Yes / No If yes, which phone? Home / Cell / Work

Email Address_____

Place of Employment_____ Occupation_____

Guarantor Name _____ Guarantor Phone_____

Emergency Contact Person and Phone Number_____

Primary Insurance_____ Group Number_____
PLEASE HAVE COPY OF YOUR INSURANCE CARD AVAILABLE FOR PHOTOCOPYING

Your Relationship to Policy Holder Self_____ Spouse*_____ Child*_____

*Policy Holder's Name_____ Employers Name_____

*Policy Holder's SSN_____ Policy Holder's DOB_____

Secondary Insurance_____ Group Number_____

*Policy Holder's Name_____ Employers Name_____

*Policy Holder's SSN_____ Policy Holder's DOB_____

Pharmacy Name_____ Location_____ Phone_____

Primary Care Provider_____ Phone_____

Referring Provider_____ Phone_____

List All Drug Allergies_____

Do You Have Any Known Risk Factors for HIV? YES / NO If yes, Please explain_____

Do You Have a History of Hepatitis? YES / NO If yes, Please explain_____

Name and Relationship to Person We May Release Your Personal Medical Information To_____

I authorize the release of any medical or other information necessary to process insurance claims. I grant consent to use and disclose protected health information for the purposes of treatment, payment, and healthcare operations. I authorize payment of medical benefits for services rendered. I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as the result of examination or treatment by Caedran Audley, APRN, FNP-C or her designee.

_____ _____
Signature of Patient Date

_____ _____
Signature of Guarantor Date

REV 2/2020