SCSPHYSICIANS skin care specialty physicians | MOHS & SKIN SURGERY CENTER

PATIENT DEMOGRAPHICS

Make sure we gŜt it right!

Please carefully fill in all the information you have available to you. Inaccuracies can lead to errors in your medical records and problems with insurance processing. Thanks!

LAST Name		**Address**	
FIRST Name		**City**	
Middle Name		**State & Zip**	

Age		**Gender**	
Birthdate		**Home Phone**	
Marital Status		**Cell Phone**	
Spouse		**Work Phone**	

Race*	Hispanic Ethnicity? (if applicable)*	Language Preference*

** Federal Guidelines now require medical practices to collect information regarding race, Hispanic ethnicity and Language preferences to help fight discrimination.*

Referring Physician		**Referring Patient**	
Primary Physician		**How did you hear about us?**	

	PRIMARY Health Ins Company	Policy Number	Group Number
Info			
	Insured Party (Policy Holder)	**Insured Party D.O.B.**	**Patient's Relationship to Insured**
Info			

	SECONDARY Health Ins Company	Policy Number	Group Number
Info			
	Insured Party (Policy Holder)	**Insured Party D.O.B.**	**Patient's Relationship to Insured**
Info			

Primary Insurance Copay		**Referral Begin Date**	
Secondary Insurance Copay		**Referral End Date**	
REFERRAL Auth Number		**# of Visits Authorized**	