

Hailey, Brody, Casey & Wray, M.D., P.C.

DERMATOLOGY AND DERMATOLOGIC SURGERY

LAST NAME _____ FIRST _____ M.I. _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOME PHONE _____ CELL PHONE _____
DATE OF BIRTH _____ SEX _____ MARITAL STATUS: S M P W D
PATIENT S.S. NO. _____
PATIENT'S EMPLOYER _____ OCCUPATION _____
EMPLOYER ADDRESS _____
CITY _____ STATE _____ ZIP _____
EMPLOYER PHONE _____ EXT. _____
SPOUSE/PARTNER/PARENT NAME _____ S.S. NO. _____ DATE OF BIRTH _____
SPOUSE/PARTNER/PARENT EMPLOYER _____ OCCUPATION _____
SPOUSE/PARTNER/PARENT EMPLOYER PHONE _____
ARE YOU A SMOKER? YES NO (CIRCLE ONE) _____ PACKS PER DAY
ALCOHOL CONSUMPTION? QUANTITY PER WEEK _____
DRUG ALLERGIES YES NO (CIRCLE ONE) LIST ALL _____

LIST ALL MEDICATIONS YOU ARE TAKING AT PRESENT _____

DO YOU HAVE: DIABETES _____, TB _____, HIGH BLOOD PRESSURE _____, CANCER _____, ULCERS _____,
LIVER DISEASE _____, SINUS, HAYFEVER, ASTHMA _____ (CHECK ALL THAT APPLY)

REFERRED BY PHYSICIAN (NAME) _____ OTHER (NAME) _____

NAME OF PERSON RESPONSIBLE FOR PAYMENT (IF OTHER THAN PATIENT)

RESPONSIBLE PARTY LAST NAME _____ FIRST NAME & INITIAL _____
RELATIONSHIP (SPOUSE/PARTNER/PARENT) _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
PHONE _____ RESPONSIBLE PARTY S.S. NO. _____
RESPONSIBLE PARTY EMPLOYER _____
EMPLOYER ADDRESS _____ EMPLOYER PHONE _____

INSURANCE INFORMATION

MEDICARE OR INSURANCE #1 NAME _____
#1 ADDRESS _____ #1 PHONE _____
POLICYHOLDER LAST NAME _____ FIRST NAME _____
RELATIONSHIP TO PATIENT _____ INSURED'S DATE OF BIRTH _____
CERTIFICATE NO. _____ GROUP NO. _____ MEMBER NO. _____
CO-PAY AMOUNT _____

INSURANCE #2 NAME _____
#2 ADDRESS _____ #2 PHONE _____
POLICYHOLDER LAST NAME _____ FIRST NAME _____
RELATIONSHIP TO PATIENT _____ INSURED'S DATE OF BIRTH _____
CERTIFICATE NO. _____ GROUP NO. _____ MEMBER NO. _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described, realizing I am responsible to pay non-covered services.

AUTHORIZATION TO PAY RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

SIGNATURE (Patient or Parent if Minor)

DATE