Are you currently under hospice care? Yes No (please circle)

Updated (06.29.15)

MCCOMB SKIN CLINIC
PATIENT INFORMATION

Name: _____ _____ _____
Last First Middle

Preferred Name: _____ **Preferred Pharmacy:** _____

Date of Birth: _____ **Gender: Male/Female** (please circle) **Social Security #:** _____

Marital status: (please circle) Married Widowed Divorced Single **Primary Language:**_____

Race: (please circle) American Indian or Alaska Native / Asian / African American / Caucasian / Pacific Islander or Native Hawaiian / Other

Ethnicity: (please circle) Hispanic / Not Hispanic **Patient Email:**_____

Mailing Address:_____ _____ _____ _____
Street/P.O. Box City State Zip

Home Phone: _____ **Cell Phone:** _____ **Circle Preferred Method of Contact: Home Cell**

Employment: (please circle) Child / Student / Employed / Retired / Unemployed

Employer: _____ **Occupation:**_____ **Work Phone:** _____

Please list person(s) with whom we may leave messages regarding your Healthcare if we are unable to reach you by phone. (Example: biopsy results, pathology reports, lab reports, prescription requests etc.)
_____
_____
_____

Primary Insurance:
Policy Holder Name:_____
Relationship of policy holder to patient_____
Policy Holder's date of birth _____
Policy Holder's address and phone # *(if different from patient)*
_____

Secondary Insurance:
Policy Holder Name:_____
Relationship of policy holder to patient_____
Policy Holder's date of birth _____
Insured's address and phone # *(if different from patient)*
_____

Contact person: **(Someone living outside the household) Name:** _____ **Phone:** _____

Family member(s) who are patients of McComb Skin Clinic:_____

Financially responsible party *(if different from patient)*:

Name: _____ Address: _____**DOB:**_____

Phone: _____ Social Security #: _____ Relationship to patient: _____

McComb Skin Clinic participates with Blue Cross Blue Shield, MS State Employee Insurance, Tricare Standard, Medicare, Medigap (supplement) policies, and United Healthcare. <u>If we do not participate with your insurance company, payment must be made at the time of service.</u>

Patient signature: _____ **Date:** _____