

# St. Louis Dermatology and Surgery Center

Name \_\_\_\_\_ Today's date \_\_\_\_\_  
Last First M.I.

Mailing Address \_\_\_\_\_ Age \_\_\_\_\_  
Number, Street, Apartment Number

City State Zip

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS # \_\_\_\_\_ Marital Status \_\_\_\_\_ Sex \_\_\_\_\_

Employer \_\_\_\_\_ Retired \_\_\_\_\_ Full Time Student \_\_\_\_\_ Part Time Student \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_

Person to notify in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_  
(Please list a person not living in your home)

Primary Care Doctor \_\_\_\_\_ Referring Doctor \_\_\_\_\_

May we leave a message on your home answering machine? Y N

May we leave a message for you at work to call us? Y N

May we discuss your medical condition with another person? Y N

If yes, whom \_\_\_\_\_ Relationship \_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_

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**If patient is a minor please enter responsible party information.** (Note: We do not bill absent parents, the adult presenting the minor for care is the responsible party.)

Name \_\_\_\_\_ SS# \_\_\_\_\_  
Last First M.I.

Address \_\_\_\_\_  
Number, Street, Apartment Number

City State Zip

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

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Policy Holder (if different from patient or responsible party) \_\_\_\_\_

Policy Holder's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_

Employer of Policy Holder \_\_\_\_\_ Work Phone(\_\_\_\_) \_\_\_\_\_

Patient's Relationship to Policy Holder \_\_\_\_\_

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**PLEASE PRESENT THIS FORM WITH YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST**