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**Personal and Insurance Information**

Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI:\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Social Security # \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

Street Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code\_\_\_\_\_\_\_\_\_

Sex: \_\_\_\_Male \_\_\_\_Female

Telephone # with area code:

(\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_

 *Home Work Mobile*

E-Mail Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_Single \_\_\_\_Married \_\_\_\_Divorced \_\_\_\_Widowed

 **\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

\_\_\_\_\_\_ YES. Check here if you would like to receive information regarding cosmetic procedures, products or promotions.

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Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Telephone: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Subscriber of Insurance (if not yourself): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

D.O.B: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_ Subscriber’s Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Primary Care Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I acknowledge and agree that I have received a copy of Washington Square Dermatology’s Notice of Privacy Practices under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Patient’s Signature Date*