

The Updegraff Clinic for Allergy & Dermatology, PC TODAY'S DATE: _____

Patient Information

NAME: _____ AGE: _____ DATE OF BIRTH: _____
ADDRESS: _____ SEX: _____ MARITAL STATUS: _____
CITY: _____ STATE _____ ZIP _____ Pharmacy name _____
HOME PHONE: _____ Pharmacy phone _____ fax _____
SOCIAL SECURITY #: _____ PERMANENT ADDRESS: _____
EMPLOYER: _____ CITY/ST/ZIP: _____
ADDRESS: _____ HOME PHONE #: _____
CITY/ST/ZIP: _____ WORK PHONE #: _____
PHONE #: _____ REFERRED BY WHOM _____

Responsible Party Information

NAME: _____ RELATION TO PATIENT: _____
ADDRESS: _____ EMPLOYER: _____
CITY/ST/ZIP: _____ ADDRESS: _____
HOME PHONE: _____ CITY/ST/ZIP: _____
SOCIAL SECURITY #: _____ WORK PHONE: _____

Primary Insurance (Please give your insurance card(s) to the receptionist)

INSURANCE CO.: _____ POLICYHOLDER'S NAME: _____
ADDRESS: _____ POLICYHOLDER SSN: _____
CITY/ST/ZIP: _____ POLICYHOLDER D.O.B: _____
PHONE # _____ POLICY #: _____
Effective dates: _____ through _____ GROUP #: _____
PLAN NAME _____ COPAY \$ _____ RELATION TO PATIENT: _____
POLICYHOLDER'S EMPLOYER: _____

Additional / Secondary Insurance

INSURANCE CO.: _____ POLICYHOLDER'S NAME: _____
ADDRESS: _____ POLICYHOLDER SSN: _____
CITY/ST/ZIP: _____ POLICYHOLDER D.O.B: _____
PHONE # _____ POLICY #: _____
Effective dates: _____ through _____ GROUP #: _____
PLAN NAME _____ COPAY \$ _____ RELATION TO PATIENT: _____
POLICYHOLDER'S EMPLOYER: _____

Miscellaneous

In case of emergency, notify _____ Relation to patient _____
Home phone _____ Work phone _____
OK to discuss medical condition? Yes _____ No _____ OK to leave phone messages? Yes _____ No _____

Signature

The undersigned verifies that the above information is true and correct.

Signature: _____ Date: _____
(If patient is a minor - signature of parent/guardian)