

Name \_\_\_\_\_ Date \_\_\_\_\_ Sex: M F  
last first middle

Address \_\_\_\_\_ Zip \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Cell # (\_\_\_\_) \_\_\_\_\_  
Home # (\_\_\_\_) \_\_\_\_\_

Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security# \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status \_\_\_\_\_

**Responsible party information:**

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Work # (\_\_\_\_) \_\_\_\_\_ Employer's Address \_\_\_\_\_

Driver's License #: \_\_\_\_\_ (please attach) Medicare #: \_\_\_\_\_ (please attach)

Blue Cross-Grp/policy#: \_\_\_\_\_ ID/Cert#: \_\_\_\_\_ **MUST SUPPLY:** Subscribers date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PLEASE SUPPLY EMAIL ADDRESS FOR APPOINTMENT CONFIRMATION AND PRACTICE UPDATES**

EMAIL ADDRESS: \_\_\_\_\_

If Minor, Name of Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_ Work # \_\_\_\_\_

**In an emergency contact** \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**List medications** and dosage which you are taking or take **regularly** (including over-the-counter herbal & vitamins)

\_\_\_\_\_ Over

List **other** medications which you take **occasionally**:  See list - attached

\_\_\_\_\_ Over

**Allergies to medications**

Check (✓) the conditions which **you** have had: \_\_\_\_\_

- |  |   |
|--|---|
| <input type="checkbox"/> Arthritis                     | <input type="checkbox"/> Hepatitis                          |
| <input type="checkbox"/> Asthma/Allergies              | <input type="checkbox"/> High Blood Pressure                |
| <input type="checkbox"/> Blood Clots                   | <input type="checkbox"/> HIV Infection                      |
| <input type="checkbox"/> Cancer (of which organ) _____ | <input type="checkbox"/> Pacemaker                          |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Tuberculosis                       |
| <input type="checkbox"/> Glaucoma                      | <input type="checkbox"/> Skin Cancer                        |
| <input type="checkbox"/> Heart disease                 | <input type="checkbox"/> Skin Disease, please specify _____ |
| <input type="checkbox"/> Heart valve disease           | <input type="checkbox"/> Ulcers                             |
|  | Other _____   |

Check (✓) the conditions which your **blood relatives** have had: \_\_\_\_\_

- Asthma/Allergies
- Diabetes
- High Blood Pressure
- Skin Cancer
- Skin Disease, please specify \_\_\_\_\_
- Other \_\_\_\_\_

Family Physician name & #: \_\_\_\_\_ Referred by \_\_\_\_\_

**Please read:**

**1. I understand that I am responsible for payment of medical services provided by the physician(s)/Skin by Design and that my entire bill for medical services is due at completion of each individual appointment. I agree that if I cancel any appointment I will give a 24 hour advance notice or there will be a \$50.00 fee for non-cancellation.**

**2. I authorize Dr. Stocker to release any and all medical records pertaining to me for any diagnosis and treatment received today or subsequently to my medical doctor(s) and my insurance company(s). Further I understand that I am responsible for any unpaid balance my insurance company does not cover and I will promptly pay. Please sign below**

X \_\_\_\_\_

**YOU MUST ATTACH YOUR DRIVER'S LICENSE**

*Signature(Patient/Guardian)*