SKIN & ALLERGY CENTER

Ben Hayes, M.D., Ph.D.
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Jamie Wilson, FNP

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Sheri Chapman, FNP
Alli Adams, FNP
Jessica Adams, FNP

PATIENT INFORMATION

Last Name:	First Name:	MI:
DOB:	SSN:	Race:	Sex: Male Female
Address:	Apt:	City:	State:	Zip:

Phone numbers: (Please mark your primary number)

	May we leave a detailed message/text?	
☐ Home #:	Yes	No
☐ Work #:	Yes	No
☐ Cell #:	Yes	No

How did you hear about us?: ☐ Referring Physician: _____ ☐ Family/Friend: _____
☐ Google Search ☐ Social Media ☐ VA

Email: Would you like to be added to our cosmetic specials email list? Yes No

Pharmacy Name: Street/City: Phone #:

GUARANTOR/RESPONSIBLE PARTY

(Required if patient is under 18)

Relationship to patient (Circle one:) Parent Child Spouse Other

Last Name:	First Name:	DOB:	SSN:
Address (if different from above):	Apt:	City:	State:	Zip:

EMERGENCY CONTACT

Name:	Relationship to patient:	Phone Number:

INSURANCE

Primary Insurance:	ID/Policy Number:		Group Number:
Policy Holder Name:	Policy Holder DOB:	Policy Holder SSN:	Relationship to Patient:
Secondary Insurance:	ID/Policy Number:		Group Number:
Policy Holder	Policy Holder DOB:	Policy Holder SSN:	Relationship to Patient:

HIPPA AUTHORIZATION

(Authorization for Use or Disclosure of Protected Health Information)

PLEASE CHECK ONE:

☐ I authorize release of information including diagnosis, records, examination, treatment, and billing to the following:

Spouse (name):	Phone Number:
Parent (name):	Phone Number:
Child (name):	Phone Number:
Other (name):	Phone Number:

☐ Information is not to be released to anyone

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____