Bakersfield Dermatology and Skin Cancer Medical Group

5101 Commerce Drive, Suite 101, Bakersfield, CA 93309
661-327-3756

Date_____/_____/_____ **Account Number**_____
(Office Use Only)

Patient Information:

Patient Name_____ **DOB**_____/_____/_____ **Age**_____
First MI Last
Mailing Address_____ **City/State/ZIP**_____

Home Ph.(_____)_____-_____ **Cell Ph.** (_____)_____-_____ **Referring Doctor**_____

Driver's License (Parent)_____ **Gender**_____ **Social Security Number**_____-_____-_____

Race: ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino **Preferred Language:** ☐English ☐Spanish ☐Other

E-mail address:_____ ☐ Decline e-mail, please.

Please answer the following questions:

May we leave information on your answering machine regarding your visit, appointments, treatments, etc.? YES NO

Have you ever been a patient in our office? YES NO **If yes, when?** _____/_____

Have other members of your family been patients in our office? YES NO **If yes, who?**_____

Consent to Treat a Minor:

I hereby authorize Bakersfield Dermatology (the Provider) to administer medical treatment or care as deemed medically necessary to my _____ (please indicate the minor's relationship to the guardian).

_____ _____ _____/_____/_____
(Name of Legal Guardian) (Signature of Legal Guardian) (Date)

Parent/Legal Guardian:

Mother_____ **DOB**____/____/____ **SSN** _____-____-_____
First MI Last
Address (If different than patient) _____
Street City/State/ZIP
Mother's Employer_____**Home/Work Phone** (____) ____-_____

Father_____ **DOB**____/____/____ **SSN** _____-____-_____
First MI Last
Address (If different than patient)_____
Street City/State/ZIP
Father's Employer_____**Home/Work Phone** (____) ____-_____

Stepparent information (If applicable) Name:_____ **DOB**_____/_____/_____

Please provide the following information as completely as possible:

Primary Insurance_____ Subscriber Number_____ Group Number_____

Subscriber Name_____ DOB____/____/____Relationship to Patient: Self Spouse Parent Other

Secondary Insurance_____ Subscriber Number_____ Group Number_____

Subscriber Name_____ DOB____/____/____Relationship to Patient: Self Spouse Parent Other

I have received the HIPAA notice of Privacy Practices, and the Insurance and Payment Policies of Bakersfield Dermatology. I authorize payment of insurance benefits and release of Protected Health Information (PHI), in accordance with HIPAA Regulations.

_____ _____
Patient (or Guardian, if patient is under 18) Signature **Date**
(Signature valid for three years from your handwritten date on this document, unless otherwise specified.)