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**_____

Employer_____ **Occupation**_____ **Primary Care/Referring Doctor**_____

Home Ph.(____)____-_____ **Work Ph.** (____)____-_____**Cell Ph.** (____)____-_____**Marital Status**_____

Driver's License_____**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 discuss your information with members of your immediate family or caregiver? YES NO

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?**_____

Spouse Information (*if applicable*)

Spouse Name_____ DOB_____/_____/_____
First MI Last

SSN _____-_____-_____ **Employer**_____**Work Ph.** (_____) _____-_____

Parent/Legal Guardian (If patient is insured by parent *or* under the age of 18)

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** (____) ____-_____

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 under 18) Signature **Date**

(Signature valid for three years from your handwritten date on this document, unless otherwise specified.)

06/2013