Damon McClain, MD, FAAD | Susannah McClain, MD, FAAD | Molly McIntyre, PA-C, MMS, MPH

Patient Demographics

Name:____ **Home Phone:** ________________________________

Date of Birth:__________________________________ **Mobile Phone:**________________________________

If Minor, Parent's Name:_________________________ **Work Phone:**_________________________________

Address:_______________________________________ **Email:**_______________________________________

City:___________________________**State:**__________ **Age:**_______**Gender:**______**Marital Status:**________

Zip Code:______________________________________ **Referring Provider:**____________________________

Social Security #:________________________________ **Primary Care Provider:**________________________

How did you hear about us?____

Insurance Information

Primary Insurance Company Name:____

Insurance Company Address:____

Insurance ID Number___________________________________ **Group Number**_______________________________________

Subscriber's Name:____

If subscriber name is different than patient name, please provide the following:

Subscriber's Birthday:_______________ **Relationship to Patient:**____________________ **Employer Name:**__________________

Secondary Insurance Company Name:____

Insurance Company Address:____

Insurance ID Number___________________________________ **Group Number**_______________________________________

Subscriber's Name:____

If subscriber name is different than patient name, please provide the following:

Subscriber's Birthday:_______________ **Relationship to Patient:**____________________ **Employer Name:**__________________