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

Patient Demographics

Name:_____ **Home Phone:** _____

Date of Birth:_____ **Work Phone:**_____

If Minor, Parent's Name:_____ **Mobile 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:**_____