Dermatology Practice of Roanoke, P.C.

Patient Name: ____

Date of Birth:_______________ Male_______ Female_____ SSN#______________________

Address:____

Street /PO Box Apt # City/State Zip

Home Phone:_______________________ Alternative Phone:________________________

Child lives with: Father_______ Mother_______ Guardian______

Father's Name:_____________________________________ Date of birth________________

SSN#___________________________________ Phone number: _______________________

Address (if different from patient)____

Employer:_____________________________ Employer or Daytime phone__________________

Mother's Name:___________________________________ Date of birth: _____________

SSN#____ Phone Number:_______________

Address(if different from patient)____

Employer:_________________________________ Employer or Daytime Phone:_______________

Guardian:_______________________________________ Date of Birth:__________________

SSN#:____ Phone Number:________________

Address (if different from Patient)____

Employer:_____________________________ Employer or daytime phone:____________________

Emergency Contact:

Name: ________________________Phone:___________Relationship_____________________

Insurance Information: We need to scan your insurance card so bring cards to each visit.

Primary Insurance:________________________ Policy number:____________________ __________

Group Number_______________________

Policy Holder Name:_____________________________ Date of Birth: _______________________

Secondary Coverage:____________________________ Policy Number:___________________________

Group number:_____________________

Policy Holder Name:____________________________ Date of Birth: ______________________________

A Parent or legal guardian is required to accompany patient to first visit. Thereafter person listed below may accompany the patient to office visits. All minors must be accompanied by an adult.

In my absence, I designate the following person(s) to make any medical or surgical decisions or to participate in the treatment of my child. I also designate them to pick up medication samples, written prescriptions, or health information that I have requested from the physician. Information about my child may be disclosed to the following person(s) to the extent of that person's involvement with my child's care or payment for care. I furthermore authorize the medical staff at Dermatology Practice of Roanoke, P.C. to carry out any medical procedures and treatments that are deemed appropriate. I understand that due to time constraints, Dr. Walter and staff are unable to take calls reiterating instructions that were given to the patient at a time of parent or guardian's absence and therefore the persons named below are responsible for sharing medical information with the parent or guardian.

1.____Relationship to Patient__________________

2. ____Relationship to Patient__________________

3. ____Relationship to Patient__________________

Responsible Party/ Parent Signature:______________________________ Date;___________________