<table>
<tr><td colspan="3">Name: (Last, First, MI)</td><td>Age:</td><td colspan="2">Sex:
M F</td><td colspan="2">Birth Date:</td></tr>
<tr><td colspan="4">Street Address:</td><td>City:</td><td colspan="2">Zip</td><td>SS#</td></tr>
<tr><td colspan="3">Mailing Address:</td><td colspan="3">City:</td><td colspan="2">Zip:</td></tr>
<tr><td colspan="4">Home & Cell Phone:</td><td colspan="4">Email Address:</td></tr>
<tr><td>Employer:</td><td colspan="5">Address:</td><td colspan="2">Work Phone:</td></tr>
<tr><td colspan="2">Email Address:</td><td colspan="3">Occupation:</td><td colspan="3">Referred by:</td></tr>
<tr><td colspan="8">In Case of Emergency (Friend or Relative not listed above. ONE MUST BE LOCAL)</td></tr>
<tr><td colspan="3">Name (1): (Last, First)</td><td colspan="5">Address:</td></tr>
<tr><td>Home & Cell Phone:</td><td colspan="5">Work Phone:</td><td colspan="2">Relation:</td></tr>
<tr><td colspan="3">Name (2): (Last, First)</td><td colspan="5">Address:</td></tr>
<tr><td>Home & Cell Phone:</td><td colspan="5">Work Phone:</td><td colspan="2">Relation:</td></tr>
</table>

Preferred Language____________________ Race______________ Ethnicity_________________ Marital Status__________________

Assignment of Benefits

I authorize Basin Dermatology to release any medical information that may be necessary to process medical/surgical claims for myself or my dependents. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and other health plans to issue payments on my behalf to Basin Dermatology. I understand that I am responsible for amounts not covered by insurance. This order will remain in effect until revoked by me in writing.

_____________________ ____

DATE SIGNATURE of PATIENT (or Parent/Legal Guardian if Patient is a minor)