Dr. Jay G. Barnett
Dr. Channing R. Barnett

Barnett Dermatology
163A East 70th Street
New York, N.Y. 10021
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Dermatology
and
Dermatologic Surgery

PATIENT INFORMATION (PLEASE PRINT)

(PATIENT) LAST NAME _____ FIRST _____ MIDDLE INITIAL ___

STREET ADDRESS_____ APT # _____

CITY_____ STATE _____ ZIP CODE _____COUNTRY _____

EMAIL _____@_____ . _____

HOME PHONE (_____) _____ WORK PHONE (_____) _____ CELL PHONE (_____) _____

DATE OF BIRTH _____/_____/_____ AGE _____ SEX: MALE / FEMALE SSN# _____ -- _____ -- _____

OCCUPATION _____ EMPLOYER _____

BUSINESS ADDRESS _____ STATE _____ ZIP CODE _____

MARITAL STATUS: SINGLE / MARRIED / WIDOWED / DIVORCED / SEPARATED

STUDENT: FULL TIME / PART TIME / NOT APPLICABLE

SPOUSE NAME: _____ OCCUPATION _____ DAY PHONE _____

HOW DID YOU HEAR ABOUT US? PLEASE CIRCLE

PHYSICIAN ANOTHER PATIENT FRIEND FAMILY INTERNET SEARCH PHONE BOOK

OTHER_____

REFERRING PHYSICIAN _____PHONE _____

IMPORTANT: This practice does not participate with any insurance plans. For those services that may be reimbursable by health insurance, we will provide you with a copy of today's bill to submit your claim. Because each insurance company has unique policies and forms, we recommend that you contact your insurance company for any questions that you may have on how to submit your claim.

I understand that payment is due in full at time of service for all services.

_____ _____

PATIENT SIGNATURE DATE