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

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Dermatology
and
Dermatologic Surgery

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_____

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

EMERGENCY CONTACT: _____ DAY PHONE_____

HOW DID YOU HEAR ABOUT US? PLEASE CIRCLE:

PHYSICIAN / PATIENT / FRIEND / FAMILY / INTERNET **/** OTHER_____

REFERRING PHYSICIAN _____PHONE_____

WHICH, IF ANY, HEALTHCARE WEBSITES DO YOU VISIT? _____

Other than Aetna, Cigna and Blue Cross and Blue Shield, we do not participate with any insurance plans. For those of you who have other insurances, we will provide you with a copy of today's bill to submit your claim for those services that may be reimbursable. 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.

INSURANCE INFORMATION

NAME OF INSURANCE COMPANY_____

NAME OF POLICY HOLDER_____

MEMBER ID_____

GROUP#_____

I understand that payment is due in full at time of service for all services. (Except for those with Aetna, Cigna and Blue Cross and Blue Shield).

PATIENT SIGNATURE_____ DATE_____