

J. Kevin Duplechain, MD, FACS

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Today's Date: ____ / ____ / ____

Age: _____

PATIENT PROFILE				
Patient Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status S M W D S	Date of Birth ____ / ____ / ____	Social Security # ____ - ____ - ____
Street Address	City, State, Zip Code		Home Phone	Cell Phone
Patient's Employer	Occupation		Business Phone	E-Mail Address
Emergency Contact Name	Phone Number			Relationship
Spouse's Name	Phone Number		Occupation	Business Phone Number
Responsible Party & Address (If other than patient, spouse or parent)				
Relative Not Living With Patient				Relationship
Address				Phone Number
PLEASE INDICATE HOW YOU WERE REFERRED TO OUR OFFICE: <input type="checkbox"/> Patient <input type="checkbox"/> Web <input type="checkbox"/> Laser Skincare <input type="checkbox"/> Real Yellow Pages <input type="checkbox"/> YellowBook <input type="checkbox"/> The Independent <input type="checkbox"/> The Times <input type="checkbox"/> Other				

IF PATIENT IS A MINOR OR STUDENT, PLEASE COMPLETE THE FOLLOWING SECTION		
Father's Name	Address	Home Phone Number
Father's Employer	Occupation	Business Phone Number
Mother's Name	Address	Home Phone Number
Mother's Employer	Address	Business Phone Number

INSURANCE INFORMATION			
ARE YOU COVERED BY MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO		Medicare Number:	
ARE YOU COVERED BY MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO		Medicaid Number:	
Primary Care Physician:			
IS THIS A WORKER'S COMPENSATION CASE? <input type="checkbox"/> YES <input type="checkbox"/> NO (IF YES, GIVE ADDRESS AND PHONE NUMBER BELOW)			
INSURANCE COMPANY - PRIMARY			
Policy Holder's Name	Policy Number	Date of Birth ____ / ____ / ____	Social Security # ____ - ____ - ____
Employer (if group plan)			Business Phone Number
INSURANCE COMPANY - SECONDARY			
Policy Holder's Name	Policy Number	Date of Birth ____ / ____ / ____	Social Security # ____ - ____ - ____
Employer (if group plan)			Business Phone Number

AUTHORIZATION	
I hereby authorize Dr. Duplechain to release to my insurance company, or its representative, including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical or surgical care. I also authorize and request my insurance company to pay directly to Dr. Duplechain the amount due to him in my pending claim for medical or surgical treatment or services, by reason of such treatment or services rendered to:	
Insured Person's Name: _____	
Insured Person's Signature: _____	Date: _____