BROOKS DERMATOLOGY PC
444 COMMUNITY DR. SUITE 102. MANHASSET, NY 11030. (516) 439-4707

PATIENT INFORMATION					**❑ New Patient ❑ Established PT**
Patient's FIRST Name:	MIDDLE:	LAST:			Social Security # :
Birth date: / /	Sex: ❑ M ❑ F	Marital status (circle one) Single / Mar / Div / Sep / Wid	Employment Status (circle one) Employed / Retired / Student / Not-Employed		Employer Name:
Your Address:	City			State:	Zip Code:
Race: ❑Decline ❑White ❑American Indian /Alaska Nat. ❑Asian ❑Black/African American ❑Nat.Hawaii/Oth Pac Islander ❑Other			Ethnic Group: ❑Non-Hispanic ❑Hispanic/Latino ❑Decline		Language: ❑English ❑Spanish ❑Other:_____
Primary Phone# : ❑ Cell ❑ Work ❑Home ( )	Alternate Phone# : ❑ Cell ❑ Work ❑Home ( )		Email Address: Appointment reminder by email? ❑ Yes ❑ No		
Referring Physician Name:	How did you hear about our office?				
Primary Physician Name:	Reason for visit:			Date of Inj/Onset:	

RESPONSIBLE PARTY:			
Person Financially Responsible [Guarantor] ❑ Self Only→Skip to insurance section ❑ Other Guarantor→Complete this section	Guarantor's Full Name:		Patient's Relationship to Guarantor: ❑ Child ❑ Spouse ❑ Other:
Address (if different):		Birth date: / /	Social Security # :
❑ No ❑ Yes			

ACKNOWLEDGEMENT:

The above information is true to the best of my knowledge. I consent to the use and disclosure of my protected health information for treatment, payment and health care operations as described in this clinic's Notice of Privacy Practices. I authorize my insurance benefits be paid directly to XXXX as indicated on the claim. I understand that I am financially responsible for all fees and balances, regardless of insurance coverage.

Patient/Guardian signature: _____ Date _____