**Nia K. Terezakis, M.D.**

**Patricia R. Hickham, M.D. Elizabeth B. Grieshaber, M.D.**

Please complete this form entirely in **print** and sign and date form. Account # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient’s Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_/\_\_\_\_\_\_\_/201\_\_

First Middle Last

Current Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# & Street / P.O. Box City State Zip Code

Permanent Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# & Street / P.O. Box City State Zip Code

Home Phone # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male / Female

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\*\*\*Required for all Accutane patients**

Address of School or Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status:\_\_\_\_\_\_\_\_\_\_ Name of Spouse/Partner:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referring Physician**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did you hear about our practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If patient is a Minor or Student**: Please give any information that is not listed above (Required):

Mother’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if different form above) # & Street / P.O. Box City State Zip Code

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Work # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(if different form above) # & Street / P.O. Box City State Zip Code

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact** (other than above) (Required):

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #( )\_\_\_\_\_\_\_\_\_\_\_\_\_ Work # ( )\_\_\_\_\_\_\_\_\_\_\_\_ (if different) # & Street City State Zip Code

**Insurance Information**: Please provide your **insurance card** and **driver’s license** or **photo ID**

Primary Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Secondary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insured / Cardholder:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_

Specialist COPAY DUE at this service $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IS THIS VISIT RELATED TO AN ACCIDENT OR LEGAL PROCEEDING? Yes\_\_\_\_\_ No\_\_\_\_\_**

**IS THIS VISIT RELATED TO WORKMAN’S COMPENSATION? Yes\_\_\_\_\_ No\_\_\_\_\_**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_/\_\_\_\_\_\_/201\_\_\_ (Staff Initial\_\_\_\_\_\_)

Signature