



**THE MENKES CLINIC**  
Medical, Surgical and Cosmetic Dermatology

**PATIENT INFORMATION**

PLEASE PRINT (PLEASE COMPLETE ENTIRE FORM)

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_  
LAST FIRST M.I. NICKNAME

Address: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
STREET APT #

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work/Cell Phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Sex: M F Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_  
CIRCLE ONE

Emergency Contact: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Marital Status: M S W D  
CIRCLE ONE

HIPPA PATIENT PRIVACY	I authorize The Menkes Clinic to discuss my appointment, financial and medical data with: Name _____ Relationship _____
	I authorize The Menkes Clinic to leave personal voice messages on phone #(s): Ph # (____) _____ Ph # (____) _____
	I request Special Privacy PProtection to restrict health information disclosure (separate form) Y ___ N___

Primary Care Physician: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

How were you referred to our office? \_\_\_\_\_

IF PATIENT IS A MINOR Parents Name \_\_\_\_\_

Work Phone Father (\_\_\_\_) \_\_\_\_\_ Work Phone Mother (\_\_\_\_) \_\_\_\_\_

**POLICYHOLDER (Member) INSURANCE INFORMATION**  
PLEASE COMPLETE ALL INSURANCE INFORMATION AND PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST.

Primary Insurance \_\_\_\_\_ Secondary Insurance \_\_\_\_\_  
COMPLETE ONLY IF APPLICABLE

Subscriber Name: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_  
NAME OF THE POLICY HOLDER NAME OF THE POLICY HOLDER

Relationship to Subscriber: \_\_\_\_\_ Relationship to Subscriber: \_\_\_\_\_

Subscriber's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Subscriber's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

