PETER B. ODLAND, M.D.
ANNALISA K. GORMAN, M.D.
JODI S. MARKUS, M.D.
MARIAM B. TOTONCHY, M.D.

SKIN SURGERY CENTER
SKIN CANCER SPECIALISTS

SARAH B. PATTON, PA-C
NICOLE M. MARSHALL, PA-C
RACHEL A. PARINE, PA-C

NEW PATIENT INFORMATION

Name:____
(last) *(first)* *(middle initial)*

Date of Birth (*mm/dd/yyyy*) ________________ Age ______________ Male ☐ Female ☐

Address:____
(street) *(city)* *(state)* *(zip code)*

Home Phone # (*land line*) : ____________________ Mobile #: ____________________ confirmation calls/texts? ☐

Work #: ____________________ Occupation: ____________________ Employer: ________________________

Email:____
(we use email frequently to communicate appointment information and do NOT send solicited material)

Relationship/Marital Status:

☐ Single
☐ Married | Spouse - name: ___________________________________ | *Also your emergency contact?* ☐

Spouse - phone #: _________________________________

*Other Relationship Status (*if you would like to include for your file*): ____

Emergency Contact: ________________ Phone: _____________________Relationship to you: ________________

Name of referring physician (*if applicable*):____

Preferred Language: ____

Ethnicity (*check applicable) Optional:*

☐ Caucasian ☐ Hispanic ☐ NOT Hispanic or Latino
☐ African American ☐ Asian ☐ Other ______________

INSURANCE INFORMATION

Primary Insurance Company: ________________________ ID# ____________________ Group # ___________

Insured Name: ____ DOB: _______________________

Secondary Insurance Company: _____________________ ID# _____________________ Group # __________

Insured Name: ____ DOB: _______________________

The information provided is true to the best of my knowledge. I authorize treatment for myself or the above individual and I understand that I am ultimately responsible for charges associated with medical services and agree to pay all bills upon receipt of the statement, unless other arrangements are made. I authorize the physician to release to my Insurance and its agents any information required to process my insurance claims. I further agree that a copy of this agreement shall be as valid as the original. I authorize my insurance company to pay the provider directly.

Signature: ____ Date: _______________________