Dermatology Center of Lake Orion

Patient Information (please print) **Today Date:**

Name: ______________________________
Last First M.I.

Address: ______________________________
Street Apt. #

City__________ State__________ Zip__________

Telephone Home: (____)__________ Cell :(____)__________

DOB: ____/____/____ Age: ______ Sex ☐ Male ☐ Female **SS#:**____-____-____

Email Address: __________@__________

Employer: __________ Telephone (Work):__________

Pharmacy Name: __________ Pharmacy Location: __________

Primary Care Provider (Doctor) Name: __________ Number: __________

Emergency Contact: __________ Relationship:__________ Number:__________

Responsible Party (Person responsible for payment)

☐ **Same as above**

Name: __________ Relationship:__________

Home Address: __________

Home Telephone: __________ Business Phone: __________

Primary Insurance

Insurance Name: __________ Co-Pay $:__________

Policy Holder/Subscriber Name: __________ Relationship: __________

Policy Holder DOB: __________ ID#__________ Group or Plan#__________

Secondary Insurance (If applicable)

Insurance Name: __________ Co-Pay$:__________

Policy Holder/Subscriber Name (if different):__________ Relationship: __________

Policy Holder DOB: __________ ID # __________ Group or Plan#__________

Consent to Medical Care

In order to provide you with medical care, we need to have written consent from you.
Dr. Turner will be happy to address any question or concerns you may have about your condition or treatment

I give my permission to Madeline Turner, D.O., and staff, to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my condition.

____
Signature of Patient (or guardian) Date

1261 S. Lapeer Suite 201, Lake Orion, MI 48360 Phone: 248-814-7546 Fax: 248-814-8900