

JEFF ALEXANDER, M.D.

6565 South Yale, #503 Tulsa, OK 74136

(918) 494-8333

PATIENT INFORMATION

Last First Middle Prefer to be called: M / F

Full Legal Name Social Security Number

Address Apt. # City State Zip

Home Telephone Cell Phone Date of Birth Marital Status

E-Mail Address Emergency Contact Name Relationship Phone Number

Primary Care Physician Name Phone Number Patient Employment Status Student?

Employer Name Address City, State Zip Work Phone Number Extension

RESPONSIBLE PARTY (if different from patient)

Responsible Party Name Employer Name Work Phone Number Extension

Date of Birth Social Security Number Relationship to Patient Other Phone Number

Spouse Name Employer Name Work Phone Number Extension

Whom may we thank for referring you? Type of skin problem? Duration

Insurance Name

Primary Insurance Carrier Claims Address City State Zip

Policy ID Number Group Number Policyholder Social Security Number

Name of Policyholder Employer Date of Birth

Insurance Name

Secondary Insurance Carrier Claims Address City State Zip

Policy ID Number Group Number Policyholder Social Security Number

Name of Policyholder Employer Date of Birth

I hereby authorize Jeff Alexander, M.D., PC to release any information necessary to secure payment of benefits on all insurance submissions. I further agree that all information submitted is true, correct and complete as of the date of my signature below.

Patient / Responsible Party Signature Date Witness

Office Use Only

Office Use Only

