Kimberly A. Rau, MD

--------- *DERMATOLOGY* ---------

Medicare now mandates that we ask all patients their date of birth, gender, race, ethnicity, and preferred language. You may write "decline to specify" if you do not wish to answer. Thank you.

Name________________________________ Nickname __________________ Male Female

Address ____

City ___________________________________ State _________ Zip Code __________________

Preferred Phone # ________________________ Alternate Phone #__________________________

Birth Date _________________________________ Married Divorced Single Partner Widowed

Preferred Language________________________

Ethnicity_________________________________ Race_________________________________

Social Security Number _XXX-XX-_______________E-mail ______________________________

Preferred Pharmacy ____

NAME ADDRESS / ZIP CODE PHONE

Primary Care Physician____

Referring Physician____

Employer Name ___________________________ Occupation_____________________________

Parent (if minor) or Spouse's Name ____

Responsible Party Information

Name ____

Address ____ Birth Date__________________

City _________________________ State _____ Zip Code _________ Phone _________________

Insurance Information – Please Present All Insurance Cards

Subscriber's Name ______________________________________ Birth Date ________________

Relationship to Patient ___________________________________