



**Bayview Dermatology and
Cosmetic Surgery, S.C.**

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Patient information (please print clearly with full detail and fill in all the blanks. Information needed for insurance claim)

Last name First name Middle initial * Social Security #

Street address and apt #, if any City & State, Zip Code Home phone#

*Employer Work address City State, Zip Code

*Work Phone # * E-mail Address

Sex: Marital status Ethnicity Birthday

**Name of the Primary Insured and Social Security Number and Date of Birth

**Primary insured employer Address and Phone Number

Primary reason for today's visit: Emergency Contact Name Relationship, Phone#

Name of primary physician

Are you allergic to anything? Yes _____ No _____

What? _____

Women Only Are you pregnant and/or planning pregnancy? Yes _____ No _____

Are your menses? reg _____ Irreg _____ none _____

List any medication that you are currently taking (including over-the counter, vitamins, herbals, etc.)

WHICH PHARMACY DO YOU USE NAME ADDRESS OR PHONE NUMBER

