

DOC TYPE: Patient Information
Front Desk Check-in
initials _____



MRN # _____

Office Location _____
Today's Date _____
 New Patient
 Name Change
 Address Change
 Insurance Change

Patient Information
Please Complete All Sections

Name (First, MI, Last) _____ Date of Birth ____/____/____ Age: ____ Sex: M F
Mailing Address (street) _____ Apt# _____
City _____ State _____ Zip _____
Home Phone (____) _____ Daytime Phone (____) _____ Mobile Phone(____) _____
SS# _____ Marital Status: Single Married Divorced Widowed Separated
Email Address _____ Would you like to receive emails from West Dermatology for patient and
practice communication only? Yes No
Employer _____ Phone Number (____) _____
Employer Address _____
Name of referring physician (Primary Care Physician) _____ Phone Number(____) _____
Preferred Pharmacy (Name/Cross Streets) _____ Zip code _____

Parent, Spouse, or Responsible Party

Name (First, MI, Last) _____ Date of Birth ____/____/____ Age: ____ Sex: M F
Mailing Address (street) _____ Apt# _____
City _____ State _____ Zip _____
Alternate Address (optional) _____
Home Phone (____) _____ Daytime Phone (____) _____ SS# _____
Employer _____ Phone Number (____) _____
Employer Address _____

Insurance Coverage - Primary

Name of Policy Holder (Insured) _____ Date of Birth ____/____/____
Insurance Comp. Name _____ Insurance Phone# (____) _____
Co-pay \$ _____ Social Security # _____
Address of Claim Center (street, city, state, zip) _____
Policy # _____ Group Name or number# _____
Policy Type: PPO EPO POS HMO If HMO, Name of Medical Group _____
Employer _____ Phone Number (____) _____
Employer Address _____
Patient's relationship to Insured: Self Spouse Child Step-child Other _____

Insurance Coverage - Secondary

Name of Policy Holder (Insured) _____ Date of Birth ____/____/____
Insurance Comp. Name _____ Insurance Phone# (____) _____
Address of Claim Center (street, city, state, zip) _____
Policy # _____ Social Security # _____ Group Name or number _____
Policy Type: PPO EPO POS HMO If HMO, Name of Medical Group _____
Employer _____ Phone Number (____) _____
Employer Address _____
Patient's relationship to Insured: Self Spouse Child Step-child Other _____