DOC TYPE: Patient Information

Front Desk Check–in initials _____

WEST DERMATOLOGY
HEALTHY SKIN IS OUR PASSION®

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 _____