Coast Dermatology
&
Laser Surgery Center

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 _____