

# A-Z Dermatology

Office Location \_\_\_\_\_

Today's Date \_\_\_\_\_

New Patient

Name Change

Address Change

Insurance Change

## Patient Information

Please Complete all Sections

Name (Last, First, M.I.) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ Sex  Male  Female

Mailing Address (street, city, state, zip) \_\_\_\_\_

Alternate Address (optional) \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Email Address \_\_\_\_\_ Would you like to receive emails from West Dermatology?  Yes  No

Marital Status  Single  Married  Divorced  Widowed  Separated

Name of referring physician (Primary Care Physician) \_\_\_\_\_

Other family members that are patients \_\_\_\_\_

## Parent, Spouse, or Responsible Party

*If different from patient*

Name (Last, First, M.I.) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_ Sex  Male  Female

Mailing Address (street, city, state, zip) \_\_\_\_\_

Alternate Address (optional) \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Email Address \_\_\_\_\_ Would you like to receive emails from West Dermatology?  Yes  No

## Insurance Coverage-Primary

Insurance Comp. Name \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Address of Claim Center (street, city, state, zip) \_\_\_\_\_

Name of Policy Holder (Insured) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy # \_\_\_\_\_ Group Name or number \_\_\_\_\_

Policy Type:  PPO  EPO  POS  HMO If HMO, Name of Medical Group \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Patient's relationship to Insured:  Self  Spouse  Child  Step-child  Other \_\_\_\_\_

## Insurance Coverage-Secondary

Insurance Comp. Name \_\_\_\_\_ Phone# (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_

Address of Claim Center (street, city, state, zip) \_\_\_\_\_

Name of Policy Holder (Insured) \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Policy # \_\_\_\_\_ Group Name or number \_\_\_\_\_

Policy Type:  PPO  EPO  POS  HMO If HMO, Name of Medical Group \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Patient's relationship to Insured:  Self  Spouse  Child  Step-child  Other \_\_\_\_\_

**Please turn form over and complete other side**