

Welcome to Our Office

Patient #: _____ Date: _____

Patient Information: (This section refers to the patient.)

Name: _____ Nickname: _____

Address: _____ City: _____ State: _____ Zip: _____

Hm Phone: _____ Wk Phone: _____ Cell Phone: _____

Social Security Number: _____ Employer: _____ Occupation: _____

E-Mail: _____ Date of Birth: ___/___/___ Sex: Female Male

Relationship to Responsible Party: Self Spouse Son Daughter Other

Responsible Party: (Person who should receive the bill if different from above.)

Name: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Hm Phone: _____ Wk Phone: _____ Social Security #: _____

Auto Injury/Work Comp/ Other (Circle) Claim # _____ Date of Accident: _____

Referring Physician: _____ **Phone:** _____

Insurance Information: (If you do not have your card with you the following information is required.)

Primary Insurance: _____ Secondary Insurance: _____

Address: _____ Address: _____

City/State/Zip: _____ City/State/Zip: _____

Phone: () _____ Phone: (): _____

Primary Insured Person: _____ Primary Insured Person: _____

ID/Policy #: _____ Suffix: _____ ID/Policy #: _____ Suffix: _____

Group #: _____ Employer: _____ Group #: _____ Employer: _____

Co-Payment \$: _____ Referral Needed? : _____ Co-Payment \$: _____ Referral Needed? : _____

Additional Parties Authorized to View Your Medical Records

Name: _____ Address: _____ Contact #: _____

Name: _____ Address: _____ Contact #: _____

Name: _____ Address: _____ Contact #: _____

Someone to Contact in Case of an Emergency

Name: _____ Relationship to Patient: _____ Phone #1: _____ Phone #2: _____

Patient Signature

Date

(I acknowledge that the above information is accurate to the best of my knowledge and agree to submit my email to Mountain View Dermatology for the sole purpose of receiving specials and information regarding skin health

I do not want to receive monthly specials from Mountain View Dermatology