Patient Information

Thank you for choosing Darst Dermatology, PC. In order to serve you properly, we need the following information.

Please Print. All Information will be confidential.

Date: ____/____/____ Patient Name: _____
First MI Last

Sex: ☐M ☐F Date of Birth: ____/____/____ Social Security #: ____-____-____

Home Phone: ____-____-____ Cell: ____-____-____ e-mail: _____

May we send appointment reminders by email? ☐ YES ☐ NO

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

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's Employer: _____ Work Phone: ____-____-____

RESPONSIBLE PARTY

(Name of person responsible for bill)

Guarantor: _____ Relationship to Patient: _____

Guarantor Address: _____ Zip Code: _____

(if different from above address)

Cell : ____-____-____ Guarantor Employer: _____ Work # ____-____-____

PRIMARY INSURANCE

Primary Insurance Company: _____ Co-Pay amount (Specialist): $ _____

NAME OF INSURED: _____ INSURED'S Date of Birth: ____/____/____

(This is the name and Date of Birth for the person listed on the card holding the insurance – the Subscriber)

ID # _____ Group # _____ Insured Phone ____-____-____

Note: It is the patient's responsibility to get any required referrals. Failure to do so may result in denied claims and the patient will be responsible for all services rendered.

SECONDARY INSURANCE

Do you have any additional insurance? ☐ Yes ☐ No If Yes, complete the following:

Secondary Insurance Company: _____ Co-Pay amount: $ _____

INSURED: _____ Relationship to Patient: _____

INSURED'S Date of Birth: ____/____/____ ID #: _____ Group#: _____

By signing below, I authorize Darst Dermatology to leave messages in reference to any items that assist in carrying out healthcare operations, including appointment reminders and normal/benign test results.

☐Home Phone ☐ Work ☐Cell ☐ Text to Cell ☐ Email address to use: _____

Emergency Contact: _____ Phone: ____-____-____ Relationship _____

MAY WE TALK TO YOUR SPOUSE ABOUT YOUR CARE? ☐ **YES** ☐ NO **SPOUSE'S NAME:** _____

Please list any other persons to whom your protected health informations can be disclosed: (e.g. parent, adult child)

Name _____ Phone # ____-____-____ Relationship: _____

Name _____ Phone # ____-____-____ Relationship: _____

Patient or Responsible Party Signature:_____ Date: _____