**PATIENT INFORMATION**

**Last name:**

**RESPONSIBLE PARTY(person responsible/paying balance owed)**

**Name**:

**First name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MI:**

**Date of birth:**   **Phone:**

**Address:**

**City:**

**Address**:

**State:**

**Zip:**  **PRIMARY INSURANCE**

**Gender:** ☐**Male** ☐**Female Marital status: \_\_\_\_\_\_\_\_\_\_\_**

**SSN:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Race:** ☐**American Indian/Alaskan Native** ☐ **White** ☐**Asian**

 ☐**Pacific Islander** ☐**African American** ☐**Decline**

**Ethnicity:** ☐ **Hispanic** ☐**Non-Hispanic** ☐**Decline**

**Preferred Language:** ☐ **English** ☐ **Spanish**

**Home phone:**

**Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policyholder:** **Relationship to patient:**  **Date of birth:**  **SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Daytime phone:**

**Address:**

**Cell phone:** **Work phone:**  **Ext**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have an Advanced Directive?** ☐Yes ☐ No

**SECONDARY INSURANCE**

**Insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policyholder:**

**Relationship to patient:**

**HOW DID YOU HEAR ABOUT US?**

☐**Physician** ☐**Family** ☐**Friend** ☐**Driving By**

 ☐**Insurance Co.** ☐**Internet** ☐**Dr. Helfman** ☐**Other**

**EMERGENCY CONTACT**

**Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of birth:**  **SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT EMPLOYMENT**

**Employment Status:** ☐**Employed** ☐**Student** ☐**Self-employed** ☐**Retired**

**Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRIMARY CARE PHYSICIAN**

**Doctor’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**By signing below, I authorize Darst Dermatology to leave detailed messages in reference to my healthcare operations**.

**Home Phone:** ☐Yes ☐ No **Cell Phone:** ☐Yes ☐No **Work Phone:** ☐Yes ☐ No **Email:** ☐Yes ☐No

**Please list any persons to whom your protected health information can be disclosed to:**

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:

 Name: Relationship:

Patient/Responsible Party:

 Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_