Darst
DERMATOLOGY

PATIENT INFORMATION

Last name: _____

First name: _____ **MI:** _____

Address: _____

City: _____

State: _____ **Zip:** _____

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: _____

Cell phone: _____

Work phone: _____ **Ext** _____

Email: _____

Do you have a living will? ☐Yes ☐ No

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: _____

RESPONSIBLE PARTY(person responsible/paying balance owed)

Name: _____

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

Address: _____

PRIMARY INSURANCE

Insurance Company: _____

Policyholder: _____

Member ID: _____

Relationship to patient: _____

Date of birth: _____ **SSN:** _____

Address: _____

SECONDARY INSURANCE

Insurance company: _____

Policyholder: _____

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 and/or Text:** ☐Yes ☐No **Work Phone:** ☐Yes ☐No **Email:** ☐Yes ☐No

***Must select Yes for at least one of the above options. Please note cellphone texts and email are not encrypted.

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

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient/Responsible Party:

Signature: _____ Date: _____