PATIENT INFORMATION:

Last Name: _____

First Name: _____ MI:_____

Address: _____

City State Zip: _____

Gender: _____ Marital Status: _____

SSN: _____

Cell Phone: _____

Home Phone/Land Line: _____

Email: _____

RESPONSIBLE PARTY (for minors):

Name: _____

Relationship to Patient: _____

Birthdate: _____ Phone: _____

Address: _____

EMERGENCY CONTACT/HIPPA: (1)

Name: _____

Relationship to Patient: _____

May we speak with this person? ☐Yes ☐No

Cell Phone: _____ Home Phone: _____

EMERGENCY CONTACT/HIPPA: (2)

Name: _____

Relationship to Patient: _____

May we speak with this person? ☐Yes ☐No

Cell Phone: _____ Home Phone: _____

EMERGENCY CONTACT/HIPPA: (3)

Name: _____

Relationship to Patient: _____

May we speak with this person? ☐Yes ☐No

Cell Phone: _____ Home Phone: _____

Birthdate: _____

Primary Care Physician (PCP):

Doctor's Name: _____ No PCP ☐

Practice Name: _____

City State: _____

Patient Employment:

Company: _____

Work Phone: _____

Do you have a living will or advanced directive?

☐Yes ☐ No ☐ I don't know

Race: ☐African American/Black ☐White
☐American Indian/Alaskan ☐Asian
☐Pacific Islander ☐Decline

Preferred Language: ☐English ☐Spanish

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Decline

How did you hear about us?

☐Physician ☐Insurance Co ☐Family/Friend
☐Internet ☐Driving By ☐Other _____

Primary Insurance:

Insurance Company: _____

Member ID: _____

Group/Plan: _____

Policyholder: _____

Birthdate: _____ SSN: _____

Relationship to Patient: _____

Secondary Insurance:

Insurance Company: _____

Member ID: _____

Group/Plan: _____

Policyholder: _____

By signing below, I authorize Darst Dermatology to leave messages in reference to my healthcare operations. You **MUST** select "**Yes**" for at least one of the **phone** options. Cell phone texts and email are not encrypted.

Cell Phone/Text: ☐Yes ☐ No Home Phone/Land Line: ☐Yes ☐ No Email: ☐Yes ☐ No

Patient/Responsible Party Signature: _____ Date: _____

10/11/2021 gd