Patient Information Sheet

Date Completed:________________________

PATIENT INFORMATION		
Patient Last Name:	First:	Middle:
Sex: ___Male ___Female	Date of Birth:	Age:
Social Security #		
Street Address:		
City:	State:	Zip:
Home #:	Moble #:	Work #:
Email Address:	Are you Military? If so: ___Active Duty or ___Retired	
Can We Text You: ___Yes ___ No	Contact Preference: ___Home ___Work ___Mobile ___Mail ___Portal	
Are You A Student: ___Yes ___No	Marital Status: ___Single ___Married ___Divorced ___Widowed ___Separated	
Student Status: ___Full Time ___Part Time		
Employment Status: ___Full Time ___Part Time ___Not Employed ___Self Employed ___Retired ___Military		
Employer:	Occupation:	
Employer Street Address:		
Employer City:	State:	Zip:
Employer Phone #:	Marital Status: ___Single ___Married ___Divorced ___Widowed ___Separated	
Former Patient at High Plains Dermatology: ___Yes ___No		

* Note: We reqeust your social security number for insurance and identity purposes but when displayed in the system it only shows the last 4 digits.

REFERRING & PRIMARY PHYSICIAN INFORMATION		
Referring Physician Name:		
Street Address:		
City:	State:	Zip:
Phone Number:	Specialty:	
Primary Care Physician Name:		
Street Address:		
City:	State:	Zip:
Phone Number:		

GUARANTOR INFORMATION (Who is responsible for you financially)		
Name:	Relationship to Patient:	
Street Address:		
City:	State:	Zip:
Home Phone#:	Work#:	Cell #:
Sex: ___Male ___Female	Date of Birth:	
Social Security #:	E-Mail Address:	
Please list other family members that Guarantor is responsible for that are Palo Duro Dermatology patients:		
Employer Name:		

EMERGENCY CONTACT INFORMATION

Name:		Relationship to Patient:
Street Address:		
City:	State:	Zip:
Home Phone#:	Work#:	Cell #:
Emergency Contact Date of Birth:		

INSURANCE INFORMATION

Is Your Visit Related To: ___Auto Accident ___Workers Compensation (If yes, a separate form will be given for workers compensation info)

PRIMARY Insurance Company Name:		
Policy #:		
Group Name:	Group #:	
Claims Street Address:		
City:	State:	Zip:
Effective Date of Insurance:		
Insurance Phone #:		
Policy Holder Name:	Relationship to Patient:	
Policy Holder Employer:		
Policy Holder Social Security #:	Sex: ___Male ___Female	
Policy Holder Date of Birth:		
SECONDARY Insurance Company Name:		
Policy #:		
Group Name:	Group #:	
Claims Street Address:		
City:	State:	Zip:
Effective Date of Insurance:		
Insurance Phone #:		
Policy Holder Name:	Relationship to Patient:	
Policy Holder Employer:		
Policy Holder Social Security #:	Sex: ___Male ___Female	

RACE, ETHNICITY & LANGUAGE INFORMATION

OPTIONAL (The government asks all healthcare providers to collect the information below.) **OPTIONAL**

Race: ___White ___Black/African American ___Asian ___More than 1 Race

Ethnicity: ___Hispanic/Latino ___Not Hispanic/Latino

Primary Language Spoken: _English ___Spanish ___Creole ___Other:______________________

How Did You Hear About Us?

___ Advertising (TV, Radio, Newspaper, Director Mail) ___ Friend ___ Insurance Directory ___ Internet Search

___ Palo Duro Dermatology Web Page

PHARMACY INFORMATION

Pharmacy Name:		
Street Address:		
City:	State:	Zip:
Pharmacy Phone#:	Pharmacy Fax#:	