DERMATOLOGY SOUTHWEST

Patient Information

Name _____
Last *First* *M.I.*

Date of Birth: ___/___/___ Age: _____ Gender: ❑ Male ❑ Female

ADDRESS:

Mailing Address _____
City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ e-mail: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: _____Date of Birth: ___/___/___
Last *First* *M.I.*

Address:_____
City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

INSURANCE COVERAGE - <u>PRIMARY:</u>

Insurance Co. Name:_____

Address of Claim Center:_____

_____
City *State* *Zip Code*

Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ___/___/___

Policy #:_____ Group Name or #:_____

Policy Type: ❑ HMO ❑ PPO

If patient is child, check relationship to insured: ❑ Mother ❑ Father ❑ Other_____

INSURANCE COVERAGE - <u>SECONDARY:</u>

Insurance Co. Name:_____

Address of Claim Center:_____

_____
City *State* *Zip Code*

Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ___/___/___

Policy #:_____ Group Name or #:_____

Policy Type: ❑ HMO ❑ PPO

If patient is child, check relationship to insured: ❑ Mother ❑ Father ❑ Other_____

Please present your insurance card(s) and a photo ID to the receptionist along with this completed form. Thank you.