MITCHELL DERMATOLOGY

PATIENT INFORMATION: New Patient Name Change Address Change Insurance Change

Today's Date ___/___/___

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Title: Mr Dr Miss Mrs Ms Nickname:______________________________

Patient Name:____
First Middle Last Suffix (Jr., III, etc.)

Date of Birth:___/___/___ Age:_______ Sex: Male Female SS#:______________________

Mailing Address:____
Apt# City State Zip

Home phone: (___)__________________________ Cell phone/pager: (___)______________________

Patient's occupation:_________________________ Work phone: ( )___________________ Ext:______

Marital status: Single Married Divorced Widowed Separated

Driver's License #:________________________ State:___________

Emergency Contact:_________________________ Relationship:____________________ Phone: (____)____________

INSURED PARENT OR /RESPONSIBLE PARTY FOR BILL PAYMENT ***(if different from patient)***

Policy Holder Name:____ __________________________
First Middle Last Relationship to Patient

Address:____
Apt# City State Zip

Home phone: (___)___________________________ Work phone: ( )___________________ Ext:________

Policy holder's Date of Birth: ___/___/___ Sex: Male Female SS#:_____________________________

INSURANCE COVERAGE – PRIMARY

Name of Insurance Co.:____ Phone: (___)_____________ Ext:______

Insurance Claim Filing Address:____
(on insurance card) City State Zip

Policy #:__________________________________ Group Name or #:_______________________________

Policy start date:____________________________

Policy type: HMO PPO Employer issuing insurance:____________________________

INSURANCE COVERAGE – SECONDARY

Name of Insurance Co.:_______________________________________ Phone: (___)_____________Ext:______

Insurance Claim Filing Address:____
(on insurance card) City State Zip

Policy Holder Name:_________________________ Policy Holder's Date of Birth:___/___/___

Policy #:_______________________________ Group Name or #:______________________________
Policy start date:_________________________ Policy Holder's SSN______________________________

Policy Type: HMO PPO Employer issuing insurance:____________________________