MOUNTAINTOP DERMATOLOGY

Patient Information Form

Please help us continue to provide you with quality care by answering all of the questions below. *Thank you!*

Date: _____

Last Name: _____ First Name: _____ Middle Initial: ____

Date of Birth (MM/DD/YY): _____ Sex M ❑ F ❑

Address: _____

City, State: _____ Zip Code: _____

Phone: (your privacy is our priority; if you do not wish us to call a number please leave that space blank)

Home: _____ Cell: _____ Work: _____

What is the first/best number for us to reach you at: Home ❑ Cell ❑ Work ❑

Is it o.k. if we leave a message on your voicemail? Yes ❑ No ❑

If yes, which phone/s? Home ❑ Cell ❑ Work ❑

Social Security Number: _____

Ethnicity / Race: _____

Preferred Language: _____

Email Address: _____

Employer Name: _____ Employer Phone #:_____

Emergency Contact Name: _____ Phone #: _____

Relationship: _____

May we discuss your medical information with this person? Yes ❑ No ❑

Do we treat other members of your family? Yes ❑ No ❑

If yes, whom _____

Primary Insurance

Insurance Name: _____

Subscriber ID: _____

Group ID: _____

Policy Holder Name: _____

Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Policy Holder's SS#: _____

Secondary Insurance

Insurance Name: _____

Subscriber ID: _____

Group ID: _____

Policy Holder Name: _____

Relationship to Patient: _____

Policy Holder's Date of Birth: _____

Policy Holder's SS#: _____

Name of Primary Care Physician: _____

Address:_____

City, State: _____ Zip Code:_____

Office Phone #: _____ Office Fax #:_____

Please check box if you **do not** want your visit notes shared with your physician ❑

Name of Referring Physician (if different from above): _____

Specialty: _____

Address:_____

City, State: _____ Zip Code:_____

Office Phone #: _____ Office Fax #:_____

Name of any other Physician/s you want us to share your visit notes with:

_____

Specialty: _____

Address:_____

City, State: _____ Zip Code:_____

Office Phone #: _____ Office Fax #: _____

Picture Consent: Clinical pictures are often taken for proper charting. Do we have your permission to use these pictures for educational purposes? Yes ❑ No ❑

How did you hear about Mountaintop Dermatology?

❑ Our Website ❑ Dex phonebook ❑ Tri-Lakes phonebook ❑ Newspaper ❑ Direct mail

❑ Insurance provider website ❑ Referral from patient. Patient name:_____

❑ Other _____

Patient Authorization:
By signing this authorization, I verify the accuracy of my demographic information. I also authorize Mountaintop Dermatology to share my protected health information (PHI) with the physicians I have listed on this form.

_____

Name (printed)

_____ _____

Signature Date