



Patient Information Sheet

(Please use black ink)

Today's Date: _____ Who referred you? _____

Patient's Name: _____
(Last) (First) (Middle) Jr. / Sr.

Patient's Mailing Address: _____
(Street) (Apt.) (City, State) (Zip Code)

Patient's Home Phone #: _____ Patient's Cell Phone #: _____

Patient's Employer: _____ Patient's Work Phone #: _____

Patient's Social Security #: _____ Marital Status: M W D S (check one)

Patient Date of Birth: _____ Age: _____ Sex: Male Female

Guarantor (responsible for minors): _____ Relationship to patient: _____

Primary Insurance Company: _____

Primary Policy Holder: _____ Relationship to patient: _____

Primary Policy Holder's Date of Birth: _____ Primary Policy Holder's SS#: _____

Secondary Insurance Company: _____

Secondary Policy Holder: _____ Relationship to patient: _____

Secondary Policy Holder's Date of Birth: _____ Secondary Policy Holder's SS#: _____

If biopsy/lab testing is necessary, may we leave results on your **answering machine**? Yes No

If biopsy/lab testing is necessary, may we leave results with **another member of your household**? Yes No
If yes, with whom and what is their relationship to you? _____

Preferred Pharmacy and Location: _____ Phone #: _____

In case of Emergency, whom should we contact (**not living with you**)? _____

Relationship to Patient: _____

Phone #: _____ (Home) and Phone #: _____ (Work Cell)

Payment is expected at the time of service for charges not covered by your insurance including office visit co-pays and deductibles. Amarillo Dermatology is not responsible for out-of-network denials or reduced benefit payments. It is the patient's responsibility to verify network benefits. Your signature below indicates that you understand and accept responsibility for the charges not covered by your insurance and authorizes this office to release medical information necessary to process your insurance claim. You authorize payment of medical benefits to AMARILLO DERMATOLOGY when a claim is filed on your behalf. The patient is responsible for lab work and pathology billed by the pathologists that are independent from our office. Amarillo Dermatology charges **\$25 for missed appointments and appointments cancelled with less than 24 hours notice.**

Patient (or Responsible Party) Signature

Date