

Atlantic Shore Dermatology

PATIENT INFORMATION AND HISTORY FORM

Chart# _____

Last Name _____ First Name _____ MI. _____ SSN _____

Sex: Male or Female _____ Date of Birth ____ - ____ - ____ Marital Status: S W D M

Home Address _____ City/State _____ Zip Code _____

Mailing Address _____ City/State _____ Zip Code _____

IS ADDRESS: PERMANENT OR TEMPORARY? (circle one)

Home Phone _____ Work Phone _____

E-mail Address _____ Cell Phone _____

Patient's Employer (if student, name of school) _____

Employer's Address _____

SPOUSE OR GUARDIAN

(Without this information, we cannot file a claim and you will be responsible for the bill the day of service.)

Name _____ Date of Birth _____ SSN _____

Employer _____ Address _____ Phone # _____

EMERGENCY CONTACTS

Nearest relative not living with you _____ Phone _____

Nearest friend not living with you _____ Phone _____

Family Physician _____ Phone _____

Referring Physician _____ Address _____ Phone _____

INSURANCE INFORMATION

***Primary Insurance Co. Name/Address _____

Insured/Policy Holder/Subscriber Name _____ Date of birth of Insured ____ / ____ / ____

Policy Number _____ Group Number _____ Date of injury _____

***Secondary Insurance Company Name/Address _____

Insured/Policy Holder/Subscriber Name _____ Date of birth of Insured ____ / ____ / ____

Policy Number _____ Group Number _____ Date of injury _____

I agree the above information is correct. _____

Print Name

Signature

Date

**** Pathology Consent ****

Are we able to leave pathology/lab results on your answering machine? Yes No

Signature: _____ Date: _____

