pure.dermatology

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PATIENT INFORMATION SHEET

First Name:_____ MI:_____ Last Name:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Email:_____

Do you wish to receive emails regarding specials and other news for Pure Dermatology? Yes / No

SSN:_____-_____-_____ Date of Birth:_____/_____/_____

Primary Phone:_____ Home / Cell / Work

May we leave a voice/text message regarding your appointments at this phone number? Yes / No

Secondary Phone:_____ Home / Cell / Work

Preferred Method of Contact: phone call / email / text message

Gender: Male / Female Marital Status: Single / Married / Separated / Divorced / Widowed

Emergency Contact:_____ Phone:_____ Relation to Patient: _____

If you would like us to be able to share your medical information, you MUST fill out a PHI Release.

If Blue Cross and Blue Shield; Federal BCBS, Allegiance or Cigna ADirect is your PRIMARY provider, please fill out the following: Please present your card, as we will also scan a copy.

Health Plan ID: _____ Group Number: _____

Policy Holder: _____ Policy Holder DOB:_____/_____/_____

Relationship to Policy Holder: Spouse / Child / Self

If the above patient is a minor, please provide the following information:
Parent/Legal Guardian:

First Name:_____ MI:_____ Last Name:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

SSN:_____-_____-_____ Date of Birth:_____/_____/_____

Primary Phone:_____ Home / Cell / Work

Secondary Phone:_____ Home / Cell / Work

Patient Signature:_____ Date: _____/_____/_____

Parent/Guardian Signature:_____ Date: _____/_____/_____

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