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PATIENT INFORMATION SHEET

First Name:________________________ MI:_____ Last Name:________________________________
Mailing Address:____
City:___________________________________ State:_____________ Zip Code:_________________
Gender: Male / Female
Primary Phone:____________________________________ Home / Cell / Work
Voice/text messages regarding your appointments will be left at this phone number.
Secondary Phone:__________________________________ Home / Cell / Work
Email:____
Do you wish to receive emails regarding specials and other news for Pure Dermatology? Yes / No
Marital Status: Single / Married / Separated / Divorced / Widowed
Date of Birth:_______/_______/____________ SSN:___________-_________-________________
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 Medicare, Blue Cross and Blue Shield; Federal BCBS, Allegiance, Cigna ADirect, UnitedHealthcare, UHC affiliates or PacificSource is your PRIMARY provider, please fill out the following: Please present your card.

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

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Patient Signature:_______________________________________ Date: ______/______/____________

Parent/Guardian Signature:______________________________ Date: ______/______/____________

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