

## 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)

To avoid misunderstanding regarding our payment policies, we need to inform you of the financial policies of this office. Payment is expected at the time of service for charges not covered by your insurance including office visit co-pays and deductibles. Amarillo Dermatology, P.A., 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. Your signature authorizes this office to release medical information necessary to process your insurance claim (if any). You herein authorize payment of medical benefits to AMARILLO DERMATOLOGY, P.A. when a claim is filed on your behalf.

\_\_\_\_\_  
Patient (or Responsible Party) Signature

\_\_\_\_\_  
Date