Group: CHDC

CHEYENNE DERMATOLOGY

New Patient Information Form

Please fill in the following information as completely as possible.

Guarantor (Responsible Party) Information:

Name _____ Today's Date _____
Address _____
Zip _____ City _____ State _____
Telephone ( ) _____ Marital Status _____
Social Security # _____ _____ _____ Employer _____
Date of Birth ___/___/___ Telephone ( ) _____ Ext. _____ Advanced Directive: Yes ___ No ___
Race _____ Ethnicity _____ Language _____ Decline to Answer ___

Patient Information:

Relation to Guarantor: Self____ Spouse____ Child____ Other_____

Last Name _____ First Name _____ MI _____
Maiden Name _____ Social Security # ___ ___ ____ Last Visit _____
Address _____
Zip _____ City _____ State _____ Email _____
Telephone ( ) _____ Referring Physician _____
Date of Birth ___/___/___ Age _____ Employer _____
Marital Status _____ Sex _____ Work Ph ( ) _____ Ext. _____ Cell Ph ( ) _____
Emergency Contact _____ Relation _____ Telephone ( ) _____
Race _____ Ethnicity _____ Language _____ Decline to Answer ___
Student: Yes ___ No ___ Full-time ___ Part-time ___ Name of School _____
Is today's visit the result of auto accident? Yes ___ No ___ Work Injury? ___ Date _____
Other Coverage _____
Spouse Name _____ Employer _____ Telephone ( ) _____

Insured (Policyholder) Information---Primary Carrier:

Please present your insurance card(s) to front counter.

Ins Co Name _____ Policy # _____
Address 1 _____ Group # _____
Address 2/City St Zip _____
Patient Relation to Insured: Self ___ Spouse ___ Child ___ Other ___
Policy Holder Name/Address 1 _____
Address 2/City St Zip _____
Telephone ( ) _____ Date of Birth ___/___/___ Sex _____
Employer _____

Insured (Policyholder) Information---Secondary Carrier:

Ins Co Name _____ Policy # _____
Address 1 _____ Group # _____
Address 2/City St Zip _____
Patient Relation to Insured: Self ___ Spouse ___ Child ___ Other ___
Policy Holder Name/Address 1 _____
Address 2/City St Zip _____
Telephone ( ) _____ Date of Birth ___/___/___ Sex _____
Employer _____

I authorize the release of all medical records to referring physicians and to my insurance company. I further authorize insurance payments to be made directly to CHEYENNE DERMATOLOGY. I understand payment is due at time of service.

Signature of Responsible Party _____ Date _____