

**PATIENT INFORMATION**  New Patient  Name Change  Address Change  Insurance Change

**THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:**

Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ Preferred to be called \_\_\_\_\_  
*Last First M.I.*

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Sex:  Male  Female Marital Status:  Married  Single  Divorced  Widowed

Employer Name \_\_\_\_\_ Employer Address \_\_\_\_\_ Employer Phone No \_\_\_\_\_ SSN \_\_\_\_\_

If referred by a Physician: \_\_\_\_\_  
Name of Physician \_\_\_\_\_ Physician's Address \_\_\_\_\_

**ADDRESS:**

Mailing Address \_\_\_\_\_  
*City State Zip*

Home Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_ e-mail: \_\_\_\_\_

Person to contact in case of emergency: \_\_\_\_\_  
*Name Address Phone #*

To whom may we discuss your care? \_\_\_\_\_  
*Name Address Phone #*

Has any other member of your family been treated in our office?  Yes  No

If yes: \_\_\_\_\_  
*Name Age Relationship*

**PARENT, SPOUSE, OR RESPONSIBLE PARTY (If different from patient)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
*Last First M.I.*

Address: \_\_\_\_\_  
*City State Zip*

Home or Cell Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

**INSURANCE COVERAGE – PRIMARY:**

Insurance Co. Name: \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
*City State Zip*

Name of Policy Holder (Insured) \_\_\_\_\_ Policy Holder's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Group Name or Employer # \_\_\_\_\_ Relationship to insured:  Self  Spouse  Child

**INSURANCE COVERAGE – SECONDARY:**

Insurance Co. Name: \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
*City State Zip*

Name of Policy Holder (Insured) \_\_\_\_\_ Policy Holder's DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Group Name or Employer # \_\_\_\_\_ Relationship to insured:  Self  Spouse  Child

In order to establish optimal relations with our patients and avoid misunderstanding regarding our patient policies, our staff is trained to inform you of the financial policies of this office. **PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE FOR "YOUR CO-PAYMENT OR YOUR PORTION OF THE CHARGES"**. FOR YOUR CONVENIENCE WE ACCEPT VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS. If you do not have insurance, payment in full is expected at the time of service, unless payment arrangements have been made. Balances on all accounts over 90 days are subject to interest charges at the rate of 1.5% per month. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Cheyenne Skin Clinic to release such medical information necessary to process your insurance claims, if any and authorizes payment of medical benefits to the physician when assigned claim is filed.

**For Office Use Only**  
Patient's  
Photograph

\_\_\_\_\_  
**Signature of Patient or Legal Guardian**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_