



DONNA WEST DERMATOLOGY

PATIENT INFORMATION

Date: _____ / _____ / _____
Mo Day Year

DOB _____ / _____ / _____
Mo Day Year

Patient's Last Name M. Initial First Name

Patient's Address Apt. No. City Zip Code Social Security #

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Home Phone # Cell Phone # Business Phone #

Marital status: S M W D

Employer Name Occupation

Name of Spouse or Parent Occupation Social Security #

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Employer of Spouse or Parent Business Phone #

Nearest Relative not living with you: _____

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Address of above relative Phone #

Referred by: _____

Medical Insurance: Yes No Name of Company : _____

I am aware that Donna West Dermatology is not contracted with any insurance company and that payment is required in full at time of service. For the convenience of our patients we do file insurance claims for PPO and POS policies. However, neither Medicare nor an HMO will accept claims from a non-contracted provider.

Signature: _____ **Staff Initials:** _____

Patients who carry medical insurance should remember that professional services are rendered and charged to the patient, not the insurance company. To avoid delays and misunderstandings, it is best to learn beforehand exactly what your policy provides and its full coverage.

I agree, in any event, that I will be responsible in full for payments.

Signature: _____

If patient is a minor:

Permission is granted to render treatment:

Signature: _____