STILLWATER DERMATOLOGY™
CLINIC
1329 S. Sangre Road

PATIENT NAME:_____ **Date of Birth**_____

Address:_____
(Street) **(City)** **(ST)** **(Zip Code)**

Home Phone:(____)____-_____ **Cell:** (____)_____-_____ **Work:** (____)____-_____

Preferred phone number for reminder calls: (____)____-_____

YOUR E-mail Address:_____

Patient's Social Security #:_____ **Patient's Employer**_____

Health Insurance Co.: _____ *(circle one)* **MALE** **FEMALE**

Referring Physician *(if any)*_____ **Phone:**_____

Primary Care Physician_____ **Phone**_____ **City**_____

RACE ***(circle all that apply):*** American Indian/Alaska Native; Asian; Black/African American; Hispanic; Native Hawaiian/Other Pacific Islander; Caucasian/White; Other_____

ETHNICITY ***(circle one):*** **Hispanic/Latino** **Not Hispanic/Not Latino**

Primary Language Spoken:_____

If patient is a child/minor please complete the following information:

Father's Name:_____ **Work #** (____)_____-_____
Mother's Name:_____ **Work #** (____)_____-_____

INSURANCE POLICY HOLDER INFORMATION *(If other than patient)*

Name of Holder:_____ **Date of Birth**_____
Address:_____ **City:**_____ **ST:**_____ **Zip:**_____
Relationship to Patient:_____ **Social Security #**_____
Name of Employer_____ **Work #** (_____)_____-_____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name:_____ **Relationship:**_____

Phone #: (_____)_____-_____

I hereby authorize the release of any medical information for insurance purposes.

_____ _____
Patient Signature/Guardian **Date**