

DATE: _____

Chatham Dermatology



Patient No: _____

PLEASE PRINT

PATIENT INFORMATION FORM

DO NOT LEAVE BLANK!

Last Name _____ First _____ MI _____ Nickname _____ SSN: _____
 Street Address: (No. P.O. Box) _____ Mailing Address: _____
 Apartment or Lot number _____ -City _____ State _____ Zip _____
 Home Phone (____) _____ Work Phone (____) _____
 Mobile Phone (____) _____ Email Address _____
 Date of Birth ____ - ____ - ____ Age _____ Sex: M F Marital Status: S M D W
 Occupation _____ Employer (or school) _____ Address _____
 Retired—Previous Occupation: _____
 Do we see any of your family members? Please list: _____

 **Whom May We Thank for Referring You to Us?** _____ Phone: _____
 If a doctor referred you, would you like us to send a letter  about your visit? Yes No

Complete info about spouse if married. OR Complete info about BOTH parents if under 18.

Wife (or Mother's information if under 18)

Social Security No: _____
 Last Name _____ First _____ MI _____
 Address _____
 City, State, Zip _____
 Home Phone _____ Cell _____ Work _____
 Date of Birth: ____ - ____ - ____ Marital Status: S M D W
 Occupation _____ Employer _____

Husband (or Father's information if under 18)

Social Security No: _____
 Last Name _____ First _____ MI _____
 Address _____
 City, State, Zip _____
 Home Phone _____ Cell _____ Work _____
 Date of Birth: ____ - ____ - ____ Marital Status S M D W
 Occupation _____ Employer _____

EMERGENCY CONTACTS

1. Nearest relative/friend not living with you _____ Phone _____
2. Nearest relative/friend not living with you _____ Phone _____

PLEASE PRESENT INSURANCE CARD (S) AND PICTURE ID TO RECEPTIONIST.

PRIMARY INSURANCE CARRIER/COVERAGE

Name _____
 Insured's Name _____

SECONDARY INSURANCE CARRIER/COVERAGE

Name _____
 Insured's Name _____

I have no medical insurance

WHICH PHARMACY DO YOU USE?

Name _____ Location _____ Phone _____

Who is /are your medical doctor (s) ? _____ **Are you under Hospice care?** Yes No
 Females: Who provides your gynecologic care? _____

- What laboratory does your insurance company specify that you use? _____ Don't know
 - Do you have a "prescription card" allowing discounts on medicines? Yes No Don't know
 - Do you use a mail order pharmacy supplying 3 month supplies of medicines? Yes No Don't know
 - With your prescriptions, which would you prefer? Brand Generic
 - Can we leave a message on your home answering machine? Yes No
 - Can we leave a message at your place of employment? Yes No
 - Can we discuss your medical condition with any family/friends? Yes No
- If yes ,whom: _____ Relationship: _____

- Check to schedule a skin cancer screening (i.e. if a history of excess sun, many moles, or skin cancer/ melanoma.) Be sure to schedule this exam with the front staff. Come with no make-up for this exam. You will be asked to remove all clothing for this exam, and a gown will be provided.
- Check here if you may be interested in the cosmetic services/products we offer.