DATE ________________

Chatham Dermatology

Patient Number ___________

PLEASE PRINT

PATIENT INFORMATION FORM

DO NOT LEAVE BLANKS

NAME: Last _______________ First _______________ MI ___ Preferred _______________ SS# _______________________

Date of Birth ___________ Age _____ Gender at Birth: M or F (Gender Identity ____________) Marital Status S M D W

Mailing Address ____ City _______________ State ____ Zip ____________

Occupation _____________ Employer (or school) ________________ ☐ Retired – **PREVIOUS** occupation________________

Do we see any of your family members? Please list: ____

COMMUNICATION: ***The ability to communicate with you is very important.***
We may need to reach you about your appointments, laboratory or pathology results, insurance or billing information, answers to medical questions you requested, or information about products/services of interest to you. By providing the information below, you consent to receiving such communication from our office unless you instruct us otherwise. You also understand the inherent risks of communication by unencrypted e-mail and text messages.

Cell Phone ______________________ Home Phone ________________________ Work Phone ________________________

E-mail Address ____

WHOM MAY WE THANK FOR REFERRING YOU TO US? ____

If a DOCTOR referred you, would you like us to send a letter about your visit? ☐ Yes ☐ No

EMERGENCY CONTACTS
Name ____ Phone __________________ Relationship ___________________
Nearest relative/friend not living with you: _______________________________________ Phone: ______________________

SPOUSE or **LIFE PARTNER**
Name: Last ____________ First ______________ MI _____
SS# _____________________ Date of Birth ____________
Address ____
City, State, Zip ____
Phone: Cell _________ Home_________ Work _________
Occupation _________________ Employer ____________

RESPONSIBLE PARENT (IF PATIENT IS UNDER AGE 18)
Name: Last ______________ First _______________ MI ____
SS# ______________________ Date of Birth _______________
Address ____
City, State, Zip _______________________________________
Phone: Cell __________ Home __________ Work __________
Occupation ______________ Employer __________________

ALL PATIENTS: ***PRESENT INSURANCE CARD(S), PHOTO ID, & PRESCRIPTION CARDS TO FRONT STAFF.***

PATIENTS OVER AGE 65 – Answer these questions. Are you under Hospice care? ☐ YES ☐ NO

Do you or your spouse have insurance coverage through work? ☐ YES ☐ NO

Did you enroll in a Medicare ADVANTAGE PLAN or HMO ? ☐ YES ☐ NO Which one? ______________________________

Your primary care provider? _____________________ Other important providers ___________________________
Local Pharmacy Name ___________________________ Location __________________________ Phone__________________
Mail Order Pharmacy Name ____________________________

What laboratory does your insurance specify that you use? ___________________________________ ☐ I don't know.

PROTECTED HEALTH INFORMATION
List any family or friends with whom we can discuss all aspects of your health information (results, prescriptions, billing, etc.).

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This information must be updated regularly according to insurance regulations. All above is accurate and up to date. If any changes occur, I will notify the office in writing.
Name ____ Date ____________________________________