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.***

As detailed in our policies you reviewed, we may send SMS/text messages to you: appointment reminders/confirmations, scheduling updates, links to intake forms and medical questionnaires, test result notifications (lab, pathology, or other), care/plan updates, prescription and refill notifications, billing and payment notifications/reminders, promotional or marketing information about our practice, and requests for reviews or feedback about your experience. 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 text and e-mail 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.).

_____

_____

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 _____