ELITE DERMATOLOGY

PATIENT DEMOGRAPHICS FORM

PATIENT INFORMATION

Patient's Last Name	First Name	MI	Date of Birth (mo/day/year)	Gender
				☐ Male ☐ Female

Mobile Phone	Home Phone	Work Phone	Preferred Phone
			☐ Work ☐ Home ☐ Mobile

Patient's Address	City	State	Zip Code

Were you referred by another physician? ☐ YES ☐ NO If yes, please list his/her name below:

Primary Care Physician	Primary Care Physician Phone	Referring Physician

Pharmacy Name	Pharmacy Phone	Pharmacy Address

BILLING AND INSURANCE INFORMATION

Responsible Party

Name (if other than patient)	Phone	Relationship to Patient	

Address	City	State	Zip Code

Primary Insurance

Name of Insured (as it appears on the insurance card)	Relationship to patient	Insured Date of Birth	Insured Phone Number

Insured Address	City	State	Zip Code

Insurance Company	Insurance Plan	Insurance Phone Number

Insurance Address	Group Number	Member ID Number

Secondary Insurance

Name of Insured (as it appears on the insurance card)	Relationship to patient	Insured Date of Birth	Insured Phone Number

Insurance Company	Insurance Plan	Insurance Phone Number

Insurance Address	Group Number	Member ID Number

MEDICAL INFORMATION PREFERENCES

May we send you mobile text message reminders of your appointment? (Please check yes or no) ☐ YES ☐ NO

May we leave messages regarding medical information or appointments on your:

Mobile phone? ☐ Yes ☐ No Home phone? ☐ Yes ☐ No Work phone? ☐ Yes ☐ No

Email? ☐ Yes ☐ No Email Address:

Would you prefer a brief or detailed message? ☐ BRIEF ☐ DETAILED

What is the best time to reach you?

I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information to the following people:

Name	Phone Number	Relationship to Patient

Name	Phone Number	Relationship to Patient

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EMERGENCY CONTACT		
Emergency Contact Name	Emergency Contact Phone Number(s)	Relationship to Patient

_____ _____ _____

Signature of patient or authorized guardian | Printed name of patient or authorized guardian | Date