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**