NORTHERN ARIZONA DERMATOLOGY CENTER

PATIENT INFORMATION

Today's Date: _____/_____/_____

PATIENT NAME: ____**Prefer to be called**:_______________

Last *First* *M.I*

Date of Birth: ______/______/______ SEX: ___M ___F Married___Single___Divorced___Other___

Mailing Address: ________________________________City:____________ State:_____ Zip Code:________

Preferred Phone Number: ____________________________ Is this number a: Cell __ Home__ Work__

E-mail:____

Name & phone # of your primary care provider: ____

How did you hear about our practice: ____

Preferred Language: ______________ Race:______________ Ethnicity: Non-Hispanic /Hispanic

Employer: _________________________________Occupation:_________________________________

Insurance Coverage – PRIMARY:

Primary Insurance: _________________________________

Name of Policy Holder (Insured) ____________________________Policy Holder D.O.B. _____/_____/_____

Policy #: _______________________ Group Name or #: ___________________

Patient's Relationship to Policy Holder: ___________________

Insurance Coverage – SECONDARY:

Secondary Insurance:________________________________

Name of Policy Holder (Insured)____________________________Policy Holder D.O.B. _____/_____/_____

Policy #: _______________________ Group Name or #: __________________

Patient's Relationship to Policy Holder:__________________

SIGNATURE: PATIENT____

DATE: __________

*** NADC adheres to the standards set forth in the Notice of Privacy Practices presented to you as part of HIPAA (Health Insurance Portability and Accountability Act of 1996)**