AV Dermatology

ph: (661) 949-0004 fax: (661) 949-5286

PATIENT INFORMATION ☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

Referred by: ☐ Insurance ☐ Our Website ☐ Google ☐ Newspaper ☐ TV/Radio ☐ Other___________

☐ Doctor Name: __________________________ Phone: ( )____________________

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Name: ____email:_________________________________
Last *First* *MI*

Date of Birth: ______/______/______ SS#: __________________________ Sex: ☐ Male ☐ Female

Address: ____
Street *City* *State* *Zip*

Home Phone: ( )_____________ Work Phone: ( )_____________ Cell Phone: ( )_____________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)

Name: ____email:_________________________________
Last *First* *MI*

Date of Birth: ______/______/______ SS#: __________________________ Sex: ☐ Male ☐ Female

Address: ____
Street *City* *State* *Zip*

INSURANCE COVERAGE – PRIMARY:

Insurance Co. Name: ______________________________________Phone: ( )______________Ext:_______

Address of Claim Center: ____
Street *City* *State* *Zip*

Name of Policy Holder (Insured):____________________________________Date of Birth:______/______/______

Policy #: ______________________________________GroupName/#:___________________________________

Policy Type: ☐ HMO ☐ PPO

Employer Name:____

Employer Address:____
Street *City* *State* *Zip*

If patient is a child, check relationship: ☐ Mother ☐ Father ☐ Other________________________________
(identify)

INSURANCE COVERAGE – SECONDARY:

Insurance Co. Name: ______________________________________Phone: ( )______________Ext:_______

Address of Claim Center: ____
Street *City* *State* *Zip*

Name of Policy Holder (Insured):____________________________________Date of Birth:______/______/______

Policy #: ______________________________________GroupName/#:___________________________________

Policy Type: ☐ HMO ☐ PPO

Employer Name:____

Employer Address:____
Street *City* *State* *Zip*

If patient is a child, check relationship: ☐ Mother ☐ Father ☐ Other________________________________
(identify)

ATTACH A COPY OF PATIENT'S INSURANCE CARD (BOTH SIDES)