SOUTHWEST SKIN CANCER AND VEIN CLINIC

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PATIENT INFORMATION SHEET

PATIENT'S PERSONAL INFORMATION

Name: _____ _____ _____ _____
First Name **Middle** **Last Name** **Prefer to be Called**

Address: _____ **Apt.#** _____ **City:** _____ **St:** **Zip:** _____

Date of Birth _____ / _____ / _____ **Gender:** ☐ **M** ☐ **F**
MM DD YYYY

Marital Status ☐ **Single** ☐ **Married** ☐ **Widowed**

Social Security # (Medicare Patients Only)
_____ / / _____

Preferred Method of Contact: ☐ **Phone** ☐ **Email** ☐ **Mail**

Phone: _____ ☐ **Home** ☐**Cell** **Secondary Phone:** _____ ☐ **Home** ☐ **Cell**

Patient's Email Address: _____ **Patient's Occupation:** _____

Do you authorize email communication for: ☐ **Appointment Reminders** ☐ **Discounts, specials, events, etc.**

WE ARE REQUIRED BY MEDICARE TO REQUEST THIS INFORMATION:

Race (circle one): **White** **Black** **Other:** _____ **Decline to Specify**

Ethnicity (circle one): **Hispanic/Latino** **Not Hispanic/Latino** **Decline to Specify**

INSURANCE INFORMATION (FOR PARTICIPATING INSURANCES)

Please provide your insurance card for us to copy.

Referring DOCTOR: _____ **Primary DOCTOR :** _____

EMERGENCY CONTACT

Name: _____ **Relationship:** _____

Phone: _____ **Secondary Phone:** _____

How did you hear about us? (Check One)

☐ **Doctor** ☐ **Insurance** ☐ **Family/Friend** ☐ **Internet** ☐ **Newspaper**

Date: _____