Where the health of your skin is on our shoulders!

ATLAS DERMATOLOGY

Patient Information *(Please print neatly!)*

Today's Date:_____

Patient Name: _____ _____
First Name Middle Initial Last Name

Mailing Address: _____ _____
Street (Include Apt # if applicable) City State Zip Code

Social Security # _____-_____-_____ Date of Birth _____

Gender: _____ Marital Status: _____ Race: _____ Language: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____ Referring/ Primary Care Physician _____

Emergency Contact

Contact Name: _____ Relationship: _____ Contact #: _____
First Name Last Name

How did you hear about us:_____ Referring Patient:_____

Insurance Policy Holder Information *(Please Present Current Insurance Card at time of Check-in!)*

Primary Insurance: _____ Secondary Insurance: _____

Member ID: _____ Member ID: _____

Policy Group #: _____ Policy Group #: _____

Name of Insured: _____ Name of Insured: _____

Date of Birth: _____ Date of Birth: _____

Insured's SS#: _____ Insured's SS#: _____

Patient Relationship to insured: _____ Patient Relationship to insured: _____

Patient/Responsible Party Signature: _____ Date: _____

For Office Use ONLY

Updated by: _____ Patient Account # _____