PATIENT INFORMATION FORM

Patient's Name _____
First Name Initial Last Name
Date of Birth (DOB): _____ Sex ___ M ___ F Social Security # _____

Address: _____

City _____ State _____ Zip _____

Home Phone: _____Work Phone: _____ Cell: _____

Email:_____

We are required to obtain the following. Please note: Primary Language is required.
If you choose not to answer Race or Ethnicity, please check "Unreported/Refuse to Report."
Primary Language of Patient: _____

Race: ___Asian ___American Indian or Alaska Native ___African American ___Native Hawaiian ___Other Pacific Islander ___White ___More than One Race ___Unreported/Refuse to Report

Ethnicity: ___Hispanic or Latino ___Non Hispanic or Latino ___Unreported/Refuse to Report.

Employer: _____Occupation: _____

Marital Status: _____Name of Spouse: _____

Name of Health Insurance: _____

Subscriber Name on Insurance: _____DOB: _____

Name of Parents (if a minor): _____

Address if Different from Patient: _____

Person Responsible for Payment: _____

Employer: _____ Address: _____

Emergency Contact:_____ Phone: _____

Primary Care Physician: _____

Address:_____ Phone: _____ Fax:_____

Do you have Tuberculosis (TB)? _____ Yes _____ No

Is there a specific laboratory your insurance requires to be used? _____ Yes _____ No

If yes, which Laboratory? _____

LifeTime Dermatology
230 W. Maple Rd., Suite 200
Troy, Mi 48084

I authorize the release of any medical information necessary to process my insurance claim and I authorize payment of medical benefits to be made to the provider listed above for the services rendered.

_____ _____
Date Signature of Patient or Parent if patient is a minor