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:_________

Is it OK to leave a detailed phone message regarding your medical information ___ Yes ___ No

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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 (248) 362-3500

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