RUSTAD DERMATOLOGY PC

Patient Information

Today's Date _____/_____/_____ ☐ New Patient Information ☐ Change of Information

Patient Data

Last Name _____ First Name _____ MI _____

Mailing Address _____ City _____ State _____ Zip _____

Date of Birth _____/_____/_____ Social Security Number _____ Marital Status _____

Required by Federal Law

Sex: ☐ Male ☐ Female Language: ☐ English ☐ Spanish ☐ Other _____ ☐ Decline to Specify

Race: ☐ White ☐ Asian ☐ Black or African American ☐ American Indian ☐ Other _____ ☐ Decline to Specify

Ethnic: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to Specify

Contact Information

Emergency Contact: Full Name _____ Phone ( ) _____

Phone Numbers

Home Phone: ( ) _____ Work Phone: ( ) _____ Mobile Phone: ( ) _____

Preferred Phone: ☐ Home ☐ Work ☐ Mobile Is it alright to leave a detailed message? ☐ Yes ☐ No

Email

E-mail Address: _____ Alternate E-mail: _____

Employer

Employer Name _____ Occupation _____ Industry _____

Insurance

Please present your PRIMARY AND SECONDARY insurance cards and photo ID. Note that if we do not participate with your insurance, or do not have an insurance card with you, FULL payment is required TODAY.

Pharmacy

Pharmacy Name _____ Address _____ City _____ State _____

Primary Care Provider (PCP)

Name _____ Office _____ City _____ State _____