

# DERMATOLOGY ASSOCIATES OF NORTHERN MICHIGAN, P.C.

## PATIENT INFORMATION SHEET

<b>PATIENT NAME</b>				
Last Name		First Name		Middle Initial
<b>PRIMARY ADDRESS</b>				
Street	Apt/Unit#	City	State	Zip Code
<b>SECONDARY ADDRESS</b>				
Street	Apt/Unit#	City	State	Zip Code

**TELEPHONE: Please check the preferred # for us to leave a confirmation call & may we leave a message? YES/NO**

<input type="checkbox"/>	Home (xxx)xxx-xxxx	YES/NO	<input type="checkbox"/>	Mobile (xxx)xxx-xxxx	YES/NO
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<b>EMAIL</b>	<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Widow	<input type="checkbox"/> Divorced	<input type="checkbox"/> Partnered
<b>PATIENT DATE OF BIRTH</b>	<b>AGE</b>	<input type="checkbox"/> Male	<input type="checkbox"/> Female	SOCIAL SECURITY #	
<b>EMERGENCY CONTACT</b>	Relationship to Patient			Phone # (xxx)xxx-xxxx	
Full Name					

<b>PRIMARY CARE PHYSICIAN</b>		<b>REFERRING PHYSICIAN</b>	
Name	Phone # (xxx)xxx-xxxx	Name	Phone # (xxx)xxx-xxxx

<b>PRIMARY INSURANCE #1</b>		<b>SECONDARY INSURANCE #2</b>	
Insurance Company Name		Insurance Company Name	
Subscriber if Different from Patient		Subscriber if Different from Patient	
Subscriber's ID Number		Subscriber's ID Number	
Group Number	Subscriber's Birthdate	Group Number	Subscriber's Birthdate
Please Circle Subscriber's Relationship to Patient Below Self Spouse Father Mother Partner Other		Please Circle Subscriber's Relationship to Patient Below Self Spouse Father Mother Partner Other	

**I give permission for my medical information or test results to be released to the following people:**

1.	Relationship:	Phone:
2.	Relationship:	Phone:
3.	Relationship:	Phone:

### IF PATIENT IS A MINOR (UNDER 18) YEARS OLD

Father's Name	Father's Daytime Phone #	Mother's Name	Mother's Daytime Phone #
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Alternate Address:

SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_