Yellowstone Dermatology

Last Name:_____ **First Name:**_____ MI:____

Date of Birth: ___/___/____ **Social Security #:**_____ **Sex:** M F

Mailing Address:_____
City_____

State: _____ Zip Code: _____ Home Phone:_____

Email Address:_____ Cell Phone:_____

Employer: _____ Work Phone: _____

Contact Preference: Home Cell Work

Billing Address: _____ City: _____ State: _____ Zip: _____

☐ Same as Mailing Address

Marital Status: Single Married Partner Divorced Widowed Separated

Spouse Name: _____ D.O.B: ___/___/___ Phone: _____

Parent/Guardian (if under 18) Name: _____ D.O.B ___/___/___

Address:_____ City: _____ State: _____ Zip: _____

Phone:_____ Relationship to Patient: _____

Language: English Spanish Other:_____

Ethnicity: _____ ☐ Decline

Race:_____ ☐ Decline

Emergency Contact

☐ Same as Spouse or Parent

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I hereby authorize to release any medical information to my insurance company. I authorize my insurance benefits to paid directly to the physician and understand that I am financially responsible for charges if they are not covered by my insurance company or if I do not have insurance.

Signature: _____ **Date:** ___/___/_____