WESTGATE SKIN & CANCER

PATIENT DEMOGRAPHICS

Blakely Richardson, DO, FAAD
Sital Patel, DO, FAAD
Board-Certified Dermatologist

PATIENT

Full Name _____ Marital Status _____

Social Security Number _____ Employment Status _____

Date of Birth _____ Gender _____ Referral Source _____

CONTACT

Address _____ Home Phone _____

City _____ State _____ ZIP _____ Work Phone _____

E-Mail _____ Mobile Phone _____

Primary Care Physician _____ Emergency Contact _____

Referring Physician _____ Emergency Phone _____

GUARANTOR / FINANCIAL RESPONSIBILITY (ONLY FOR MINORS, LEGAL GUARDIANS, OR POWER OF ATTORNEY)

Guarantor Name _____ Address _____

Relationship _____ City _____ State _____ ZIP _____

Phone _____ E-Mail _____ DOB _____

E-MAIL LIST SIGN-UP:

☐ Cosmetic Specials ☐ Flash Sales ☐ Compensated Clinical Trials ☐ Newsletter

FINANCIALS

Self-Pay: ☐ Yes ☐ No

Primary Insurance Company _____ Relationship to Policy Holder _____

Primary Policy Number _____ Policy Holder Name _____

Primary Policy Group _____ Address _____

Policy Holder DOB _____ Gender _____ City _____ State _____ ZIP _____

Secondary Insurance Company _____ Relationship to Policy Holder _____

Secondary Policy Number _____ Policy Holder Name _____

Secondary Policy Group _____ Address _____

Policy Holder DOB _____ Gender _____ City _____ State _____ ZIP _____

RELEASE OF MEDICAL RECORDS

I authorize Westgate Skin & Cancer to release my medical records to: ☐ Emergency Contact ☐ Guarantor ☐ Other

Other Contact Name _____ Relationship _____ Phone _____

SIGNATURE

I understand that my signature below confirms that the information on this form is accurate and complete to the best of knowledge.

_____ _____

Patient, Guardian, or Responsible Individual Signature Date Signed