DCI Dermatology
Clinic of Idaho

Today's Date _____/_____/_____

PATIENT INFORMATION			
Patient Name Last First Middle			**Home Phone Number** ( )
Mailing Address City State Zip Code			**Work Phone Number** ( )
Birthdate	□ Single □ Married □ Divorced □ Widowed	□ Male □ Female	**Cell Phone Number** ( )
Email Address		**Social Security #**	
Employer		**Occupation**	

RESPONSIBLE PARTY		
Guarantor (if patient is a minor)	**Relationship to Patient**	**Birthdate**
Address (if different than patient)		**Phone Number**

INSURANCE INFORMATION	
Primary Insurance	**Secondary Insurance**

SUBSCRIBER INFORMATION		
Subscriber Name	**Relationship to Patient**	**Birthdate**

EMERGENCY CONTACT			
Name (Last, First)	**Relationship**	**Home Phone Number** ( )	**Other Phone Number** ( )
Primary Care Physician			

How Were You Referred?

□Family/Friend □Mailer/Outreach □Print Ad □ Referring Provider □Social Media □Website □Yellow Pages

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

_____ _____

Patient/ Guardian Signature Date