DERMATOLOGY ASSOCIATES
OF NORTHERN MICHIGAN, P.C.

PATIENT INFORMATION SHEET

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

TELEPHONE: Please check the preferred # for us to use & indicate if we can leave a message on that # YES/NO

❑ Home (xxx)xxx-xxxx YES/NO	❑ Mobile (xxx)xxx-xxxx YES/NO

EMAIL	❑ Single	❑ Married	❑ Widow	❑ Divorced	❑ Partnered
PATIENT DATE OF BIRTH	**AGE**	❑ Male	❑ Female	SOCIAL SECURITY #	
EMERGENCY CONTACT Full Name	Relationship to Patient			Phone # (xxx)xxx-xxxx	

PRIMARY CARE PHYSICIAN		**REFERRING PHYSICIAN**	
Name	Phone # (xxx)xxx-xxxx	Name	Phone # (xxx)xxx-xxxx

PRIMARY INSURANCE #1		**SECONDARY INSURANCE #2**	
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:
2.	Relationship:
3.	Relationship:

IF PATIENT IS A MINOR (UNDER 18) YEARS OLD

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

SIGNATURE_____ DATE:_____