WASATCH DERMATOLOGY
Compassion. Tradition. Excellence.

PLEASE PRINT CLEARLY AND FILL OUT FORM COMPLETELY

Patient name: _____ Social Security # _____

Patient's DOB_____ Age_____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Patient Address: _____

City_____ State_____ Zip _____ Phone: _____

Emergency Contact: _____ Emergency Contact Phone # _____

Send E-mail Notifications? ☐ Yes ☐ No E-mail Address: _____

Send Text Message Notifications? ☐ Yes ☐ No Phone number: _____

Employment Status: ☐ Employed ☐ Student ☐ Retired ☐ Unemployed

Employer's Name: _____ Phone: _____

Primary Care Physician: _____ **Referring Physician**: _____

RESPONSIBLE PARTY INFORMATION (Guarantor)
(If you are 18 or older OR the parent OR guardian of a minor, you must complete this section as responsible party)

☐ Same as patient above (If same as above, skip to Insurance Information)

Name:_____ DOB:_____ Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian

Address: _____ City_____ State_____ Zip _____

Contact Number: _____ Work Phone: _____

INSURANCE INFORMATION (FILL OUT COMPLETELY)

Primary Insurance:_____ Policy/ID #_____Group # _____

Policy through Employer? ☐ Yes ☐ No Employer: _____Phone: _____

Insured/Policy Holder Information: _____
Name Address

Policy Holder Phone: _____ Social Security # _____Date of Birth: _____ ☐ Male ☐ Female

Secondary Insurance: _____Policy/ID #_____ Group # _____

Insured/Policy Holder Information: _____
Name Address

Policy Holder Phone: _____Social Security # _____Date of Birth: _____ ☐ Male ☐ Female

Signature_____ **Date**_____