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's Address: _____**City**: _____ **State**: _____ **Zip:** _____

Cell Phone (for text messaging): _____ **Home Phone**: _____

Email Address:_____

Emergency Contact: _____ **Emergency Contact Phone #:** _____

Employment Status: □ **Employed** □ **Student** □ **Retired** □ **Unemployed**

Employer's Name: _____ **Phone**: _____

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**: □ **Parent** □ **Legal Guardian**

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

Contact Number: _____ **Work Phone:**_____

INSURANCE INFORMATION (PLEASE FILL OUT COMPLETELY)

Primary Insurance: _____ **Policy/ID #:** _____ **Group #:** _____

Insured/Policy Holder Information: □ **Same as patient**

_____

Name **Address**

Social Security #: _____ **Date of Birth**: _____ □ **Male** □ **Female**

Secondary Insurance: _____ **Policy/ID #:** _____ **Group #:** _____

Insured/Policy Holder Information: □ **Same as patient**

_____

Name **Address**

Social Security #: _____ **Date of Birth:** _____ □ **Male** □ **Female**

Signature (Guarantor if under 18): _____ **Date**: _____