NORTHWEST DERMATOLOGY GROUP

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PATIENT INFORMATION SHEET

Last Name_____ First Name_____ M.I. _____

___ Male ___ Female ___ Other Birth date_____

Address_____City_____

State_____ Zip Code_____ Marital Status: ___S ___M ___W ___D ___O

E-mail: _____ Home Phone #: _____

Cell Phone #: _____ Work Phone #: _____

Which is your preferred contact: _____ Cell ____ Home ____ Work

May we contact you by phone regarding test results and other important medical information
____Yes ____No If yes, Which is your preferred contact: _____ Cell ____ Home ____ Work

Emergency Contact (*different number then above, name and relation*)

_____

In case of emergency of medical importance, may we contact this person on your behalf?
_____ Yes _____No

SS#_____

Employer _____ Occupation _____

Employer Address:

_____

Primary Doctor (Internist or Family Doctor) Please Include Name, Address, and Phone #

_____

Who Referred You To This Office? _____

The Following Three Questions Are Mandated By The Government To Ask

Place a checkmark by your race:
___Caucasian ___African-American ___American Indian ___Asian ___Other

Place a checkmark by your ethnicity: ___Latino ___Non-Latino Other _____

Place a checkmark by your preferred language: ___English ___Spanish ___Sign ___Other