WEST HILLS DERMATOLOGY GROUP

7320 WOODLAKE AVE, SUITE 340 WEST HILLS, CA 91307
(818) 592-6005 p www.westhillsdermatology.com (818) 592-6088 f

Patient Information ❑ New Patient ❑ Name Change ❑ Address Change ❑ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ___/___/___

Name

_____
Last *First* *M.I.*

Date of Birth: ___/___/___ Age: _____ Gender: ❑ Male ❑ Female

Race: ❑American Indian or Alaska Native ❑Asian ❑Native Hawaiian or Other Pacific Islander
❑ Black or African American ❑Hispanic or Latino ❑ White

Referred by:

❑Yelp ❑Google ❑Dr. _____ ❑Relative/Friend _____ ❑Other_____

ADDRESS:

Mailing Address

_____
City *State* *Zip*

Home Phone: ( )_____ Work Phone: ( )_____

Cell Phone: ( )_____ e-mail: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: _____ Date of Birth: ___/___/___
Last *First* *M.I.*

Address:_____
City *State* *Zip*

Home Phone: ( )_____Work Phone: ( )_____

INSURANCE COVERAGE - PRIMARY:

Insurance Co. Name:_____ Address of Claim Center:_____

_____
City *State* *Zip Code*

Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ___/___/___

Policy #:_____ Group Name or #:_____

Policy Type: ❑ HMO ❑ PPO

If patient is child, check relationship to insured: ❑ Mother ❑ Father ❑ Other_____

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INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name:_____ Address of Claim Center:_____

_____

City *State* *Zip Code*

Name of Policy Holder (Insured):_____

Policy Holder (Insured) Date of Birth: ___/___/___ Policy #:_____

Group Name or #:_____

Policy Type: ❑ HMO ❑ PPO

If patient is child, check relationship to insured: □Mother □Father □ Other

_____

Please present your insurance card(s) and a photo ID to the receptionist along with this completed form. Thank you.