

WEST HILLS DERMATOLOGY GROUP

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

Farnaz Gaminchi, M.D. Tasneem Poonawala, M.D. Kerry Schlosser, PA-C Amelia Mittleman, PA-C

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

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.***