WEST HILLS DERMATOLOGY GROUP

7320 WOODLAKE AVE, SUITE 340 WEST HILLS, CA 91307
(818) 592-6005
□Farnaz Gaminchi, M.D. □Sarah G. Maggio, D.O. □Kerry Schlosser, PA-C

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

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

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

INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name:_____

Address of Claim Center: _____

_____

Name of Policy Holder (Insured):_____

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

Policy #:_____ Group Name or #:_____

Policy Type: ❑ HMO ❑ PPO

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