

# Patient Information Sheet -Page 1

Dermatology and Laser Institute of Colorado, P.C.

Please print and complete ALL fields to ensure proper filing

## PATIENT INFORMATION:

TODAY'S DATE \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_  
(Last) (First) (Middle Initial)

Mailing Address \_\_\_\_\_  
(City) (State) (Zip)

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Sex M / F Martial Status S / M / D / W  
(Circle One)

## PARENT OR RESPONSIBLE BILLING PARTY:

Same as above

Name \_\_\_\_\_  
(Last) (First) (Middle Initial)

Mailing Address \_\_\_\_\_  
(City) (State) (Zip)

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_ Social Security # \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Sex M / F Martial Status S / M / D / W  
(Circle one)

## PRIMARY INSURANCE

Insurance Name \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Holder's Address  Same as above \_\_\_\_\_ (City) (State) (Zip)

Employer Name \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_\_\_

## SECONDARY INSURANCE Not Applicable

Insurance Name \_\_\_\_\_ Policy Holder's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Policy Holder's Address  Same as above \_\_\_\_\_ (City) (State) (Zip)

Employer Name \_\_\_\_\_ Policy Holder's Date of Birth \_\_\_/\_\_\_/\_\_\_ Social Security # \_\_\_\_\_