Integrated Dermatology of Mission Viejo, APMC
26691 Plaza, Ste 230, Mission Viejo, CA 92691-6300

Tel 949-364-2904
Fax 949-364-2909

Patient Information

DEMOGRAPHICS

Last Name: ____________ First: ____________ Middle: ____________

DOB *m/d/yyyy* ____________ Sex *check* ❑Male ❑Female SSN: ____ - ____ - ____

Age ______ Weight *in lb* ______ Height ______ Name Suffix ______

Marital Status *check one* ❑Married ❑Single ❑Other Profession: ____________

Ethnicity: ____________ Preferred Language: ____________

By whom were you referred to this office? ____________

CONTACT

Home Address: ____________

City ____________ State ______ Zip ______

Home Phone Cell Email

Automated appointment reminder preference *(check one)* ❑ Text ❑ Call cell phone ❑ Call home phone

Emergency Contact Name: ____________ Relationship to patient: ____________

Address: ____________ Phone: ____________

Employer: ____________ Work Address: ____________

PCP Name: ____________ Phone: ____________

PCP Address: ____________ Fax: ____________

INSURANCE

Primary Insurance: Insurance Type: ❑ PPO ❑ HMO ❑ EPO ❑ Medicare ❑ Medi-Cal ❑ TRICARE

If HMO, which network? ____________ Secondary Insurance ____________

Name of responsible party for bill if *NOT* patient ____________ Relationship to patient ____________

Party's DOB *mm/dd/yyyy* ____________ SSN: ____________ Phone: ____________

Party's Address ____________

By signing below, I acknowledge that under the penalty of law all information provided above are true and correct to the best of my knowledge.

Patient Signature ____________ Date ____________
or Guardian/Legal representative for patient *yyyy/mm/dd*