PATIENT INFORMATION

Armstrong Dermatology and Skin Cancer Center, P.A.
9170 Oakhurst Road, Suite #1
Seminole, FL 33776

PATIENT INFORMATION ☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

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

Name: _____
Last First Initial

Date of Birth: _____/_____/_____ **Age:** _____ **Social Security #**_____ **Sex:** ☐ **Male** ☐ **Female**

Mailing Address: _____
Street City State Zip

Secondary Address: _____
Street City State Zip

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

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**

Occupation: _____**E-Mail Address** _____

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

Name: _____
Last First Initial

Address: _____
Street City State Zip

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

Date of Birth: _____/_____/_____ **Social Security #** _____ **Sex:** ☐ **Male** ☐ **Female**

INSURANCE COVERAGE – PRIMARY

Insurance Co. Name: _____**Phone: (** **)** _____ **Ext.** _____

Address of Claim Center: _____
Street City State Zip

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

Policy # _____ **Group Name or #** _____

Policy Type: ☐ **HMO** ☐ **PPO** **Social Security #** _____

Employer Name: _____

Employer Address: _____
Street City State Zip

If Patient Is a Child, Check Relationship: ☐ **Mother** ☐ **Father** ☐ **Other (Identify)** _____

INSURANCE COVERAGE – SECONDARY

Insurance Co. Name: _____**Phone: (** **)** _____ **Ext.** _____

Address of Claim Center: _____
Street City State Zip

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

Policy # _____ **Group Name or #** _____

Policy Type: ☐ **HMO** ☐ **PPO** **Social Security #** _____

Employer Name: _____

Employer Address: _____
Street City State Zip

If Patient Is a Child, Check Relationship: ☐ **Mother** ☐ **Father** ☐ **Other (Identify)** _____