

Affiliated Dermatologists of Virginia

Patient Demographic and Insurance Information

Date: _____ Chart Number: _____
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Sex: _____ Marital Status: _____
Date of Birth: _____ Social Security Number: _____
Primary Care Physician: _____
Employer: _____ Work Phone: _____
Responsible Party (If patient is a minor): _____
Responsible Party's Employer: _____
Phone Number: _____ Address: _____

Primary Insurance Company

Subscriber Name: _____ Insurance Company: _____
Patient Relationship to Subscriber: _____ Subscriber Birthday: _____
Identification Number: _____ Subscriber SSN: _____
Co-Payment Due: _____ Group: _____

Secondary Insurance Company

Subscriber Name (On Card): _____ Insurance Company: _____
Patient Relationship to Subscriber: _____ Subscriber Birthday: _____
Identification Number: _____ Subscriber SSN: _____
Co-Payment Due: _____ Group: _____

Emergency Contact

In case of an emergency, who should be notified: _____
Phone: _____ Relationship to Patient: _____
Do you give this office permission to discuss your medical information with family members: Yes _____ No _____
Name: _____ Relationship: _____
Phone Number: _____
I certify that the above information has been completed accurately:
Patient's Name: _____
Patient's Signature: _____ Date: _____