

# SHAH DERMATOLOGY, LLC

ARPANA A. SHAH, MD, FAAD COLLEEN CLARKE, CRNP ANGELA CALLANDER, CRNP CHRISTINE WOOD, CRNP

PATIENT ACCOUNT NUMBER:	<b>PLEASE PRINT ALL INFORMATION</b>	DATE:
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**PATIENT INFORMATION**

NAME (LAST, FIRST, MI)		SOCIAL SECURITY NUMBER		
STREET ADDRESS		CITY	STATE	ZIP
HOME PHONE	WORK PHONE		CELL PHONE	
EMAIL ADDRESS				
<b>PREFERRED METHOD OF CONTACT</b> <input type="checkbox"/> EMAIL <input type="checkbox"/> HOME PHONE <input type="checkbox"/> WORK PHONE <input type="checkbox"/> CELL PHONE		OK TO LEAVE A MESSAGE AT PREFERRED CONTACT? <input type="checkbox"/> YES <input type="checkbox"/> NO		
SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> UNKNOWN <input type="checkbox"/> WIDOWED	AGE	DATE OF BIRTH	HAVE YOU BEEN SEEN IN THIS OFFICE BEFORE? YES NO
OCCUPATION		EMPLOYER		
WORK ADDRESS		IS YOUR CONDITION WORK RELATED?		
SPOUSE'S NAME (LAST NAME, FIRST NAME, MI)		SPOUSE'S DATE OF BIRTH		
STUDENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> NOT A STUDENT	PRIMARY CARE PHYSICIAN	ADDRESS	PHONE	

**I AUTHORIZE SHAH DERMATOLOGY, LLC TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) ABOUT ME TO THE PARTIES LISTED BELOW. (WE MAY DISCUSS YOUR MEDICAL CONDITION WITH THESE INDIVIDUALS)**

NAME	NAME
RELATIONSHIP	RELATIONSHIP
CONTACT NUMBER	CONTACT NUMBER

**PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN PATIENT**

NAME	RELATIONSHIP	
ADDRESS		
OCCUPATION	EMPLOYER	PHONE
ADDRESS	WORK PHONE	

**POLICY HOLDER INFORMATION**

*PRIMARY INSURANCE INFORMATION*

INSURANCE COMPANY	NAME OF POLICY HOLDER	
GROUP #	CERTIFICATE/POLICY ID #	POLICY HOLDER'S DATE OF BIRTH
MEDICARE #	MEDICAID #	POLICY HOLDER'S SOCIAL SECURITY NUMBER

*SECONDARY INSURANCE INFORMATION*

INSURANCE COMPANY	NAME OF POLICY HOLDER		POLICY HOLDER'S SOCIAL SECURITY NUMBER
GROUP #	CERTIFICATE/POLICY ID #	POLICY HOLDER'S DATE OF BIRTH	

**\*\*\*\*THE FOLLOWING QUESTIONS ARE REQUIRED BY THE US GOVERNMENT\*\*\*\***

If you choose to not answer them, please check DECLINE TO SPECIFY

LANGUAGE	RACE	ETHNICITY
<input type="checkbox"/> DECLINE TO SPECIFY <input type="checkbox"/> SPANISH <input type="checkbox"/> ENGLISH <input type="checkbox"/> OTHER	<input type="checkbox"/> DECLINE TO SPECIFY <input type="checkbox"/> AMERICAN INDIAN/ALASKAN <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK/AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> HAWAIIAN/PACIFIC ISLANDER	<input type="checkbox"/> DECLINE TO SPECIFY <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> NON-HISPANIC/NON-LATINO

**PHARMACY INFORMATION**

NAME	ADDRESS	PHONE
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