10011 S. Centennial Pkwy, Suite 200 . Sandy, UT 84070 . Ph: 801.255.7546 . Fax: 233.3444

Discover your TrueSkin DERMATOLOGY AND SURGERY, INC.

Date: _____ **Paul E. Harrison, MD**

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State:_____ Zip:_____

Employer Name: _____ Address: _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Social Security Number: _____ Marital Status: _____ Male: _____ Female: _____

Spouse or Guardian: _____ Patient Student Status: ____Not a student _____ Full Time_____Part Time

If Applicable:
Name of Facility: _____ Address: _____
(i.e. ,treatment facility, assisted living, etc.)
Phone Number: _____ _____
City State Zip
Name of Legal Guardian and/or Power of Attorney: Phone No:

Address: _____ City: _____ State: _____ Zip: _____

IF PATIENT IS A MINOR

Name of Person Responsible for Bill: _____ Date of Birth: _____
Last First M.I.
Address _____ City: _____ State: _____ Zip: _____

Relationship: _____ Social Security Number: _____ Spouse: _____

Home Phone: _____ Employer: _____ City/State: _____

Work Phone: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY

Name: _____

Address: _____

Policy Holder's Name & Address: _____

_____
Street City State Zip

Policy Holder's Date of Birth: _____

Policy No: _____

Group No: _____ Co-Pay: $_____

SECONDARY INSURANCE COMPANY

Name: _____

Address: _____

Policy Holder's Name & Address: _____

_____
Street City State Zip

Policy Holder's Date of Birth: _____

Policy No: _____

Group No: _____ Co-Pay: $_____

REFERRING PHYSICIAN

Name: _____ Phone: _____

Address: _____ City: _____ State:_____ Zip: _____

Other Family Members Seen by Dr. Harrison: _____

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU Rev. 06 2010