

Sierra Skin Institute

10479 Double R Blvd.

Reno, NV 89521

Ph: 775-850-8600 – Fax: 775-850-8665

DATE: _____

PATIENT INFORMATION

Patient Name: _____
(last) (first) (middle)

Physical Address: _____
(street) (city, state) (zip)

Mailing Address: _____
(street) (city, state) (zip)

Phone Number: _____ Birthdate: _____ E-mail Address: _____

Social Security Number: _____ Sex: F M Marital Status: S M D W

If a Minor, Parents' Names: _____
(mother) (father)

Emergency Contact: _____
(name) (home phone) (cell phone) (work phone) (relationship)

How did you hear about us? _____

EMPLOYMENT INFORMATION

PATIENT
Occupation: _____ Work Phone: _____

Employer: _____

Employer Address: _____
(street) (city, state) (zip)

SPOUSE/PARENT
Spouse/Parent's Name: _____ Occupation: _____

Employer: _____ Work Phone: _____

INSURANCE INFORMATION

PRIMARY INSURANCE
Name of Subscriber: _____ Relationship to Patient: _____

Birthdate of subscriber: _____ Social Security Number: _____

Employer: _____ Work Phone: _____

Employer Address: _____
(street) (city, state) (zip)

Insurance Company: _____

Policy Number: _____ Group Number: _____

SECONDARY INSURANCE
Name of Subscriber: _____ Relationship to Patient: _____

Birthdate of subscriber: _____ Social Security Number: _____

Employer: _____ Work Phone: _____

Employer Address: _____
(street) (city, state) (zip)

Insurance Company: _____

Policy Number: _____ Group Number: _____

I understand that co-payments are due at time of visit. I authorize payment of my medical benefits from my insurance company to Sierra Skin Institute. I also authorize release of any medical information necessary to process my medical claim. I realize that I am responsible for any balance my insurance company does not pay/cover.

Signature: _____ Date: _____

I have no insurance and agree to pay my balance in full at each visit.

Signature: _____ Date: _____

