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)

Home Phone #: _____ **Cell Phone #:** _____ **Birthdate**:_____

E-mail Address: _____ **Sex**: F M **Marital Status**: S M D W

Social Security Number: _____

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:_____