King Dermatology
2062 Hwy 62 W
Mountain Home, AR 72653
Telephone: 870-425-5464 Fax: 870-425-5465

Patient Information Form

Patient Name: ____
Last First MI Suffix

Date of Birth:_____/_____/________ **Gender:** M__F__ **Social Security #:**______________________________

Mailing Address:____
City State Zip

Physical Address: (if different) ____
City State Zip

Main Phone #:____________________ **Cell #:**_____________________ **Work #:**_______________________

Preferred Method of Communication for Appt. Reminder ___Text ___ Phone ___Email

OK to Leave Msg: Home____ Cell___ Work___ **Email Address:**_____________________________________

Marital Status (circle): Single Married Divorced Widowed

Race: White/Caucasian Hispanic Black/African American Other Race

Ethnicity: Hispanic or Latin Not Hispanic or Latin Refuse to report

Language: English Indian Spanish Russian Other

Employer Name:_____________________________ **Address:**____

Emergency Contact Name:__________________________________ **Phone Number:**________________________
Relationship:___________________________ **Address (if different):**____________________________________

Parent /Guardian Name/POA:_________________________________ **Phone Number:**_______________________
Address:____**Date of Birth:**________________________

Primary Insurance:____ **Policy Holder:**_______________________
Policy Holder Date of Birth:_____/_____/_______ **Policy Holder Social Security #:**_______________________
Policy Holder's Employer:__________________________________ **Employer Phone:**_____________________

Secondary Insurance:______________________________________ **Policy Holder:**_______________________
Policy Holder Date of Birth:_____/_____/_______ **Policy Holder Social Security #:**_______________________
Policy Holder's Employer:__________________________________ **Employer Phone:**_____________________

NOTICE: Any labs or pathology will be outsourced and billed separately.

Please be prepared to show the following cards: Primary and Secondary Insurance, Pharmacy Benefits, Driver's License or Other Form of I.D.

By signing below, I certify that the information I have provided is true and accurate to the best of my knowledge.

Signature of Responsible Party: ____**Date**______________________