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

Home Phone #:__________________ ☐ Cell #:___________________ ☐ Work #:____________________ ☐
Please indicate Preferred Phone with a √ in the box

OK to Leave Msg: Home____ Cell___ Work___ Email Address:______________________________________

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

Marital Status (circle): Single Married Divorced Widowed

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

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

Language: English Spanish Other

Receive Statements:

Online : ____

*Email : ____

*Text: ____

Paper: ____

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_____________________