

Southern Tier

DERMATOLOGY & AESTHETICS

200 Plaza Drive
Vestal, NY 13850
607.729.2777

Patient Information Sheet

PATIENT NAME:

Last Name _____ First Name _____

MAILING ADDRESS:

Street _____

Zip _____ City _____ State _____

TELEPHONE NUMBERS:

(H) _____ (W) _____ (C) _____

DATE OF BIRTH: _____ E-MAIL _____

GENDER *Male* / *Female*

MARITAL STATUS S / M / D / W OTHER _____

SOC SEC #: _____

EMPLOYER NAME: _____

EMPLOYEE STATUS: _____ RETIRED _____ FULL TIME _____ PART TIME _____

STUDENT STATUS: _____ PART TIME _____ FULL TIME _____

REFERRING PHYSICIAN: _____ Telephone _____

PRIMARY CARE PROVIDER: _____ Telephone _____

EMERGENCY CONTACT:

Last Name: _____ First Name: _____

Relationship to patient: _____ Telephone: _____

INSURANCE INFORMATION: Guarantor (person holding the insurance policy)

Last Name: _____ First Name: _____

Address of Insured: _____ City: _____ ZIP: _____

Date of Birth: _____ Telephone: _____ Gender: *MALE / FEMALE*

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Subscriber Identification #: _____

Relationship to Guarantor: _____

Coverage Information:

Do you have a co-pay? Y / N

Do you have a deductible? Y / N

Do you owe a certain percent? Y / N

If so, what is it for specifically \$_____

If so, has it been met? Y / N

If so, what percent?_____

Please take a moment to tell us how you heard about us. Thank you. _____

