Piedmont HealthCare
DERMATOLOGY

Wolfe Dermatology Intake Form

(Please print legibly and fill in all fields)
Patient Information as of (Today's date)

Patients Legal Name: First, Middle,Last

Address:

SS#: - - **Birth date:** / / **Sex:** ☐Female ☐Male

Marital Status: **Spouse's Name**

Home Phone: **Work Phone:**

Cell Phone: **Email:**

Employer:
Employer Address:

Fill out this section if Patient is a minor or nursing home patient:
Responsible Party Name: **Relationship:**
DOB: / / **SS#:** - - **Home Phone:**
Work Phone: **Employer:**

INSURANCE INFORMATION:
1)Primary Health Insurance Company:

Policy #: **Group #** **Specialist Copay:**

Insured: Name **DOB:** / /
Employer:

SS#: - - **Patient's Relationship to Insured:**

2) Secondary Health Insurance Company:

Policy #: **Group #** **Specialist Copay:**

Insured: Name **DOB:** / /
Employer:

SS#: - - **Patient's Relationship to Insured:**