THE INDIANA SKIN CANCER CENTER PATIENT INFORMATION FORM

PATIENT INFORMATION		
Patient Name:	**DOB:**	**SSN: (for billing purposes only)**
Mailing Address:		
Email Address:		
Home#:	**Cell #:**	**Other #:**
Please circle best contact phone number: HOME CELL OTHER		
Emergency Contact Name:		**Contact#:**
Primary Care Physician:		**PCP #**
Preferred Pharmacy:		**Pharmacy #:**
I have an Advance Directive or Living Will (Circle): YES NO		
Gender (Circle): Male Female	**Preferred Language (Circle):** English, Other_____	
Do you live in a Skilled Nursing Facility? (Circle) YES NO	**Are you on Hospice? (Circle)** YES NO	

PRIMARY INSURANCE INFORMATION **Name of Insurance Company:**	**ID #:**	**Group #:**
	Subscriber DOB:	**Relationship:**
Subscriber Name:	**Subscriber Address:**	
SECONDARY INSURANCE INFORMATION **Name of Insurance Company:**	**ID #:**	**Group #:**
	Subscriber DOB:	**Relationship:**
Subscriber Name:	**Subscriber Address:**	

I have read and made changes to all the above information. To my knowledge the information is accurate.

X_____ DATE_____