**PATIENT PERSONAL AND INSURANCE INFORMATION FORM**

MT LEBANON DERMATOLOGY, PC
PHONE: 412-440-0270
FAX: 412 440-0271

PLEASE FILL IN THE FOLLOWING PERSONAL AND INSURANCE INFORMATION AND RETURN IT TO US WITH YOUR MEDICAL HISTORY FORM.

**PLEASE PRINT CLEARLY**

DATE OF YOUR APPOINTMENT:_____

NAME_____
***(Please enter your name exactly as it is on your insurance card!)***

ADDRESS:_____

DATE OF BIRTH:_____ GENDER M F (PLEASE CIRCLE ONE) RACE:_____

ETHNICITY: **Please circle one**
**NOT OF SPANISH/ HISPANIC ORIGIN -----SPANISH/ HISPANIC ORIGIN**

HOME PHONE:_____

CELL PHONE:_____

WORK PHONE:_____EXT._____

PHARMACY WITH LOCATION AND PH#_____

PATIENT EMAIL:_____@_____

THE NAME OF YOUR PCP:_____

IF REFERRED, THE NAME OF THE REFERRING PHYSICIAN:_____

NAME OF THE PERSON WHO SUBSCRIBES TO YOUR INSURANCE:_____

_____

DATE OF BIRTH OF THE INSURANCE SUBSCRIBER:_____

ADDRESS OF INSURANCE SUBSCRIBER:_____

NAME OF YOUR INSURANCE PLAN:_____

ADDRESS OF YOUR INSURANCE PLAN:_____

PHONE NUMBER OF YOUR INSURANCE PLAN:_____

SPECIALIST COPAY IF ANY:_____

YOUR INSURANCE ID NUMBER:_____

YOUR INSURANCE GROUP NUMBER:_____