ROBBINS
Dermatology P.C.

Amber Robbins, M.D., F.A.A.D.
Amy LeDoux, P.A.-C
Cathy Parish, FNP-C, DCNP
Joseph Sottile, P.A.-C
1662 S. Sheridan Ave., Sheridan, WY 82801
Phone (307) 672-8941 **Fax** (307) 672-7461

Patient Legal Name: _____
Last *First* *M.I.*

Preferred Name: _____ Marital Status: S M W D Sex: M F T/NB

Date of Birth: ____/____/_____ Social Security Number: _____

Mailing Address: _____
City *State* *Zip*

Primary Phone: _____ Secondary (or Work) Phone: _____

*If you have included a cell phone, you are giving our office or assignee permission to call that phone

Preferred Pharmacy: _____

Preferred Language: (please circle one)

English Spanish Other

Race: (please circle one)

White Hispanic American Indian Other

Ethnicity: (please circle one)

Hispanic or Latino Not Hispanic or Latino

E-Mail: _____

(*Providing your email will enable you to access our web portal.)*

Employer Name: _____

Responsible Party (if patient is a minor) ***OR*** *Emergency Contact*

Name: _____ Date of Birth: ____/____/_____

Address: _____ Phone: _____

Insurance Policyholder Name, DOB, address *(if different from above)*:

_____

_____

*I HEREBY GIVE PERMISSION TO THE PERSON(S) LISTED BELOW TO RECEIVE INFORMATION ABOUT THE CARE OF THE ABOVE NAMED PATIENT (OPTIONAL)

Name:_____ Relationship to patient:_____
Name:_____ Relationship to patient:_____

Payment Policy

You will be responsible for paying your annual deductible, co-payment and charges for any non-covered cosmetic services at the time of service. If you do not have medical insurance, payment is expected at the time of service unless other payment arrangements are made in advance.

_____ Date _____/_____/_____
Signature of patient (**OR** guardian if patient is under 18)