David F. Young MD, PC
DERMATOLOGY

David F. Young MD, PC
Esther Carson, PA-C
Christa Cavanaugh, PA-C
Drew Lakey, PA-C

PATIENT INFORMATION

Date:_____ Referred by:_____

Primary Care Physician:_____ City:_____ State:_____

Name:_____ _____ _____ Birthdate:_____
(Patient last name) (First) (MI)

Mailing Address:_____ _____ _____ _____
(Street) (City) (State) (Zip)

Email Address (for appt. reminders and electronic statements):_____

Preferred Telephone #:_____ Alt. #:_____ Work #:_____

Social Security #:_____ Marital Status:_____ Gender: ____Male ____Female

Preferred Language: ____English ____Spanish Other:_____ I prefer not to say____

Race:_____ Ethnicity: ____Hispanic/Latino ____Other

Employer's Name:_____ Phone:_____

Parent/Guardian Name:_____ Birthdate:_____ Soc Security #:_____
(Last) (First) (MI)

Parent/Guardian Address:_____ _____ _____ _____
(Street) (City) (State) (Zip)

Parent/Guardian Employer:_____ Employer Phone:_____

Spouse Name:_____ Employee:_____

Spouse Employer Address:_____ Phone:_____

ADDITIONAL CONTACT INFORMATION

Name of friend/relative (not living with you):_____

Relationship:_____ Phone:_____

Primary Insurance:_____ Member ID #:_____ Group #:_____

Subscriber:_____ Subscriber Birthdate:_____ Relationship:_____

Secondary Insurance:_____ Member ID #:_____ Group #:_____

Subscriber:_____ Subscriber Birthdate:_____ Relationship:_____

I authorize the office of David F Young, MD, PC to use and/or disclose my health and financial information to the person(s) listed below (include phone numbers):

_____Spouse:_____ Children:_____

_____Other:_____

_____YES, it is ok to leave a message on my phone _____NO, it is NOT ok to leave a message on my phone.

By signing below *I acknowledge* that I have received a copy of the Notice of Privacy Practices, and *consent* to your disclosure of my information as deemed necessary in order to provide me with proper treatment.

Signature (Patient or parent/guardian):_____Date:_____

Patient *refused* to sign due to the following circumstances:_____

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