EAST TENNESSEE
DERMATOLOGY
GROUP
R. Paul Unkefer, M.D.

# PATIENT INFORMATION

**PLEASE PRINT CLEARLY**

**Name:** _____ **Male:** ☐ **Female:** ☐

**Date of Birth:** _____ **Social Security #:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Home Phone** (____) _____-_____ **Cell Phone** (____) _____-_____

**Emergency Phone** (____) _____-_____ **Work Phone** (____) _____-_____

**Employer:** _____

**Primary care physician:** _____

**Referring physician:** _____

**Referring physician address:** _____ **Telephone #:**_____

**Do you have Insurance? Yes:** ☐ **No:** ☐

**Primary Insurance Company:** _____

**Relationship to policy holder: Self:** ☐ **Spouse:** ☐ **Dependent:** ☐

**Name of policy holder:** _____

**Date of Birth:** _____ **Social Security #:** _____

**Employer:** _____

**Secondary Insurance Company:** _____

**Relationship to policy holder: Self:** ☐ **Spouse:** ☐ **Dependent:** ☐

**Name of policy holder:** _____

**Date of Birth:** _____ **Social Security #:** _____

**Employer:** _____

**Signature:** _____ **Date:** _____