



6701 South Minnesota Avenue  
Sioux Falls, SD 57108  
(605) 322-6960 • Fax (605) 322-6961

# Patient Information

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widow Occupation: \_\_\_\_\_

Sex:  Male  Female Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Address: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Work Phone #: \_\_\_\_\_

## RESPONSIBLE PARTY/BILLING INFORMATION (if patient is a minor)

Mother's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_

Address: \_\_\_\_\_  
Street PO Box City/State/Zip Home Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Father's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Soc. Sec. No.: \_\_\_\_\_

Address: \_\_\_\_\_  
Street PO Box City/State/Zip Home Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

## EMERGENCY CONTACT

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Relationship: \_\_\_\_\_

**I consent to treatment for myself or my family from  
Avera Medical Group Dermatology.**

Patient/Guardian/POA Signature \_\_\_\_\_ Date: \_\_\_\_\_