



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)

Address: _____

Street: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different from above) _____

Preferred Telephone # _____ Alt. # _____ EMAIL: _____

Social Security# _____ Marital Status _____ Gender: _____ Male _____ Female

Preferred Language: _____ English _____ Spanish Other: _____

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: _____ Phone: _____

ID#: _____ Group#: _____

Subscriber: _____ Birthdate: _____ Sex: M/F Relationship: _____

Secondary Insurance: _____ Phone: _____

ID# _____ Group# _____

Subscriber: _____ Birthdate: _____ Sex: M/F 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:

_____ 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: _____