



**HIGH VALLEY  
DERMATOLOGY**  
& DERMATOLOGIC SURGERY

Lindsay D. Sewell, MD  
Brandon L. Miner, DO  
Lena E. Gowing, DO  
Joseph D. Anderson, PA-C

2085 Providence Way  
Idaho Falls, ID 83404  
(208) 525-4888

**\*\*How did you hear about us? Internet\_\_\_ Phone Book\_\_\_ Billboard\_\_\_ Dr. Referral\_\_\_ Radio/TV\_\_\_ Other\_\_\_\_\_**

**PATIENT INFORMATION - CONFIDENTIAL**

**Primary Care Doctor: \_\_\_\_\_**

|                           |       |            |            |                |
|---------------------------|-------|------------|------------|----------------|
| <b>Patient Name:</b>      |       | Last       | First      | SSN            |
| Address                   |       |            | Apt#       | Date of Birth  |
| City                      | State |            | ZIP        | Gender         |
| Home Phone                |       | Cell Phone |            | Marital Status |
| Employer                  |       | Email      |            | Work Phone     |
| <b>Spouse/Parent Name</b> |       | Last       | First      | Date of Birth  |
| Address                   |       |            | Apt#       | SSN            |
| City                      | State |            | ZIP        | Home Phone     |
| Employer                  |       |            | Work Phone |                |

**Insurance Information**

|                          |  |                     |           |               |
|--------------------------|--|---------------------|-----------|---------------|
| <b>Primary Insurance</b> |  |                     | Phone     | CoPay Amount  |
| ID No.                   |  |                     | Group No. |               |
| Policyholder Name        |  | Relation to Patient |           | Date of Birth |
| SSN                      |  | Work Phone          |           | Employed By   |

|                            |  |                     |           |               |
|----------------------------|--|---------------------|-----------|---------------|
| <b>Secondary Insurance</b> |  |                     | Phone     | CoPay Amount  |
| ID No.                     |  |                     | Group No. |               |
| Policyholder Name          |  | Relation to Patient |           | Date of Birth |
| SSN                        |  | Work Phone          |           | Employed By   |

"By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue wellness exam, balances due, lab results, or any other healthcare related function. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me."

**For Minor Patients Only**

I authorize High Valley Dermatology to treat minor patients when **NOT** accompanied by parent or legal guardian.

\_\_\_\_\_  
**Signature / Relationship to Patient**

\_\_\_\_\_  
**Date**

**Signature**

**Date**