Amber Robbins, M.D., F.A.A.D.
Amy LeDoux, P.A.-C
Cathy Parish, FNP-C, DCNP
206 N. Brooks St., Sheridan, WY 82801
Phone (307) 672-8941 Fax (307) 672-7461

Patient Legal Name: ____
Last *First* *M.I.*

Preferred Name: ________________________ Marital Status: S M W D Sex: M F T/NB

Date of Birth: ____/____/_____ Social Security Number: __________________________

Mailing Address: ____
City *State* *Zip*

Primary Phone: ________________ Secondary (or Work) Phone: __________________

*If you have included a cell phone, you are giving our office or assignee permission to call that phone

Preferred Pharmacy: __________________________________

Preferred Language: (please circle one) Race: (please circle one)

English Spanish Other White Hispanic American Indian Other

Ethnicity: (please circle one)

Hispanic or Latino Not Hispanic or Latino

E-Mail: ____

(*Providing your email will enable you to access our web portal.)*

Employer Name: ________________________________

Responsible Party (if patient is a minor) ***OR*** *Emergency Contact*

Name: ____ Date of Birth: ____/____/_____

Address: ____ Phone: ____________________

Insurance Policyholder Name, DOB, address *(if different from above)*:

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*I HEREBY GIVE PERMISSION TO THE PERSON(S) LISTED BELOW TO RECEIVE INFORMATION ABOUT THE CARE OF THE ABOVE NAMED PATIENT (OPTIONAL)
Name:________________________ Relationship to patient:________________________
Name:________________________ Relationship to patient:________________________

Payment Policy
You will be responsible for paying your annual deductible, co-payment and charges for any non-covered cosmetic services at the time of service. If you do not have medical insurance, payment is expected at the time of service unless other payment arrangements are made in advance.

____ Date _____/______/______
Signature of patient (**OR** guardian if patient is under 18)