Dermatology Associates P.C. Date:_____

Patient Information

Date of Birth**:** _____

Name: _____ Sex: M__ F__
Last First M.I.
Address:_____
Mailing Address City State Zip Code
Home Phone:_____ Work Phone:_____ Cell Phone:_____
Preferred Phone for contact (Home, Work, or Cell):_____ May we leave a message? Y__ N__
E-mail:_____ Marital Status: Single__ Married__ Divorced__ Widowed__

Ethnicity (required): Hispanic or Latino __ Not Hispanic or Latino __ Unknown __ Declined to Specify__

Preferred Language (required):_____

Race (required): American Indian or Alaska Native ___ Asian ___ Black or African American___White___
Native Hawaiian or Other Pacific Islander___Other Race___Declined to Specify___

Parent or Responsible Party

Name of Responsible Party (Last, First) _____
Patient Relationship to the Responsible Party (Circle one): Self Spouse Child Other
Address (If different from above)_____
Home Phone _____ Work Phone _____ Cell Phone _____
Date of Birth _____

Insurance

Primary Insurance Company Name _____
Policy Holder Name _____ Policy Holder Date of Birth _____
Policy Number _____ Group Number _____ Employer _____
Policy Holder Address (If different from above)_____
Relationship to Policy Holder _____

Secondary Insurance Company Name _____
Policy Holder Name _____ Policy Holder Date of Birth _____
Policy Number _____ Group Number _____ Employer _____
Policy Holder Address (If different from above) _____
Relationship to Policy Holder _____

Primary Care Physician: _____

Emergency Contact: _____ Phone _____

Revised: 8/08; 3/09; 4/10; 3/11; 6/14; 7/14