Dermatology Center for Skin Health Patient Information Form
PLEASE PRINT

Patient Name: _____ Date of Birth: ____/____/____ Today's Date: ____/____/____

Address: _____
Street City State Zip Code

Email Address: _____

Preferred phone number: _____ ☐ Cell ☐ Home ☐ Office

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Ethnicity & Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race

Preferred Language: ☐ English ☐ Arabic ☐ French ☐ Spanish ☐ Other_____

Did another physician refer you? ☐ YES ☐ NO If yes, please list the name of the physician:_____

If you were not referred, how did you hear about our office? _____

If any medications are prescribed today, what pharmacy do you use? _____

Pharmacy location: _____

PLEASE COMPLETE THE INSURANCE SECTION BELOW IN ADDITION TO PROVIDING US WITH A COPY OF YOUR CARD

PRIMARY INSURANCE

Name of the insured:_____

Insured's Date of Birth: ____/____/____

Relationship to insured: _____

SECONDARY INSURANCE (if different from primary)

Name of the insured:_____

Insured's Date of Birth: ____/____/____

Relationship to insured: _____

In case of Emergency, who should be notified? _____

Phone: _____ Relationship to patient:_____

May we leave personal medical information on your answering machine or cell phone? ☐ YES ☐ NO

Completed by:

☐ Patient _____ ____/____/____ ____/____/____
Signed by Patient Date Updated

☐ Patient's Guardian _____ ____/____/____ ____/____/____
Signed by Patient's Guardian Date Updated

_____
Please print name

Please present your insurance card(s) to the receptionist along with this completed form. Thank you.