The Center for Dermatology Care

Patient Information Sheet (Please print or write legibly)

Patient Name: _____ Social Security #: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female Marital Status: S ● M D W

Address: _____ Day Phone: _____

Cell Phone: _____

_____ Home Phone: _____

City State Zip Code Email address: _____

Allergies: _____ Referred By: _____

Has any family member been treated by us before? ☐ Yes ☐ No If so, who? _____

Do you have health insurance? ☐ Yes ☐ No Primary Insurance Company: _____

Policyholder's Name: _____ Date of Birth: _____

Policyholder's Social Security #: _____ Relation to Patient: _____

Secondary Insurance Company: _____

Policyholder's Name: _____ Date of Birth: _____

Policyholder's Social Security #: _____ Relation to Patient: _____

May we leave personal medical information on your home answering machine? ☐ Yes ☐ No
May we leave personal medical information on your Cell Phone Voice Mail? ☐ Yes ☐ No
May we discuss your medical/billing information with family members? ☐ Yes ☐ No If yes, please provide their names and phone numbers below:

Name: _____ Relationship: _____

Day Phone: _____ Cell Phone: _____ Home Phone: _____

Name: _____ Relationship: _____

Day Phone: _____ Cell Phone: _____ Home Phone: _____

Please present your insurance card(s) and your photo ID to the receptionist for photocopying. You will be asked to update your Patient Registration Form once a year to assure we have current information.

_____ Date: _____

Patient/Parent/Legal Guardian Signature