DERMATOLOGY AND COSMETIC MEDICINE SPECIALISTS

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Date:_____

PATIENT INFORMATION

Patient's Name (Last):	First:	Middle:	Home Phone:	Cell Phone:

Patient's Address:	City:	State:	Zip:

Sex	Date of Birth	Marital Status	Phone# best to contact you:	
M ☐ F ☐		Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other ☐	Home ☐ Cell ☐	

Email Address: Personal Email ☐ Family Email ☐

Reminder Calls: (*How would you like to receive?)* Check ALL that apply Home Phone ☐ Cell Phone ☐ Text Message ☐ Email ☐

Consent to receive automated remider calls on cell phone (if checked above): _____ (please intial here)

Language:	Race: White ☐ Asian ☐	Ethnicity: Hispanic or Latino ☐
English ☐ Other ☐ (Specify) _____	Black or African American ☐ Other ☐	NOT Hispanic or Latino ☐

How did you hear about us?: Internet/Web-site ☐ Family Member/Friend ☐ Referring Physician ☐ Insurance ☐ Other ☐

GUARANTOR/RESPONSIBLE PARTY: (IF DIFFERENT FROM ABOVE)

DERMATOLOGY PATIENTS ONLY (NON COSMETIC)

Guarantor's Name (Last)	First	Middle	Home Phone	Cell Phone

Guarantor's Address	City	State	Zip

EMERGENCY CONTACT: ALL PATIENTS PLEASE COMPLETE

Name:	Phone:	Relationship:
Name:	Phone:	Relationship:

INSURANCE INFORMATION: DERMATOLOGY PATIENTS ONLY (NON COSMETIC)

PRIMARY INSURANCE: (Please complete and present insurance card to receptionist)

Primary Insurance Company Name:	Policy Holder Name:	Policy Holder Date of Birth:

Policy Number: Group Number:	Relationship: Self ☐ Spouse ☐ Parent ☐ Other ☐	Specialist Co-pay:	Policy Holder Employer:

SECONDARY INSURANCE: (Please complete and present insurance card to receptionist)

Secondary Insurance Company Name:	Policy Holder Name:	Policy Holder Date of Birth:

Policy Number: Group Number:	Relationship: Self ☐ Spouse ☐ Parent ☐ Other ☐	Specialist Co-pay:	Policy Holder Employer:

PHYSICIANS

Primary Physician:	Phone:

Address:	City:	State:	Zip:

Were you referred to our practice?: Yes ☐ No ☐	Referring Physician:	Phone:

Address:	City:	State:	Zip: