Dermatology and Skin Care ASSOCIATES, P.C.

Patient Name _____ D.O.B. _____ SS# _____

Street Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work Phone _____

Email _____

Employer/School _____ Responsible Party _____

How did you find our about our practice? _____

Emergency Contact Name/Relationship _____ Emergency Contact Phone _____

Primary Care Physician _____ PCP Phone _____

PCP Address _____ City _____ State _____ Zip _____

These questions are required by FEDERAL STANDARDS. You may leave responses blank.

Race *(select as many as applicable)*

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American

☐ Hispanic or Latino ☐ Native Hawaiian/other Pacific Island ☐ White

Ethnicity

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Language Spoken

☐ English ☐ other: _____

INSURANCE

Primary Company _____

Policy # _____

PLEASE GIVE YOUR INSURANCE CARD TO STAFF

Subscriber _____

Subscriber's Date of Birth _____

Relationship _____

Secondary *(if applicable)* _____

Policy # _____

PLEASE GIVE YOUR INSURANCE CARD TO STAFF

Subscriber _____

Subscriber's Date of Birth _____

Relationship _____