PERIMETER DERMATOLOGY

# ***PATIENT INFORMATION***

Name _____

Date of Birth _____/_____/_____ Age _____ Sex ____ Marital Status _____

Mailing Address _____
*City* *State* *Zip*

Home Phone _____ Work Phone _____ Cell _____

***Is it ok to leave a detailed message at any of the above numbers? Yes_____ No_____ (Home, Work, Cell)***

Email _____

**Preferred Method of contact:** Phone (Home, Work, Cell) Email Mail Patient Portal

***PARENT, or EMERGENCY CONTACT***

Name _____
*Last* *First* *M.I.*

Address_____
*City* *State* *Zip*

Home Phone _____ Work Phone_____
*Area Code* *Area Code*

***INSURANCE INFORMATION (Please present insurance card and Driver's License at time of check in.)***

Policy Holder _____ Male _____ Female _____

Policy Holder's Date of Birth _____/_____/_____

***Policy Holders Address***: _____

_____

Relationship of patient to the Insured _____

Pharmacy of choice _____ Phone _____

Name of Referring Physician: _____Phone_____

Mailing Address _____
*City* *State* *Zip*

Primary Care Physician _____Phone_____

Mailing Address _____
*City* *State* *Zip*

**Ethnicity: (circle which apply)** Hispanic/Latino Not Hispanic/Latino Decline to answer

**Race: (circle which apply)** American Indian/Alaskan Native Asian White Black/African American Decline to answer

**Preferred Language**: _____

**Place of Birth**: _____

**Patient or Responsible Party Signature** _____ Date ____/____/___