THE SKIN SURGERY CENTER, PA

MR#____________ Today's Date: ____________

Prefix ☐Mr. ☐ Mrs. ☐Miss ☐Ms. ☐Dr. **Preferred Name:**

Patient's Name:

First Middle Last

Address:

Street & Apt # City State Zip

SS#: Birthdate Age: Sex: ☐ Female ☐Male

Marital Status: ☐ Single ☐ Married to: ☐ Other:

Home Phone: Work Phone: Ext: Cell Phone:

Preferred Contact: ☐Home ☐Work ☐Cell ☐Email **E-mail Address:**

Any restrictions for contacting you? ☐No ☐Yes If yes, please describe

Emergency Contact: Relationship to Patient: Phone#

Race: ☐African-American ☐Asian ☐American Indian/Alaska Native ☐Native Hawaiian or Other Pacific Islander ☐White

Ethnicity: ☐Hispanic ☐ Non-Hispanic **Preferred Language:**

How did you hear about us? ☐ Dr. Dermatologist ☐ Dr. Primary Care ☐Newspaper ☐ Patient Referral ☐ Website ☐Yellow Pages Details:

Referring Care Dr.: **Primary Care Dr.:**

INSURANCE INFORMATION

Primary Ins.: Insured: Name:

Relationship to the insured? ☐Self ☐Child ☐Spouse ☐Other DOB: SS#:

Secondary Ins.: Insured: Name:

Relationship to the insured? ☐Self ☐Child ☐Spouse ☐Other DOB: SS#:

RESPONSIBLE PARTY

Name: Address:

Relation to Patient: Birth Date:

PHARMACY

Pharmacy: Phone: Street Name/City/St/Zip:

PERMISSION TO DISCUSS

Is there any other physician other than those listed above that you wish to have medical information sent to?

Name: Address:

With whom may we discuss your account?

Name: