Today's Date:_____/_____/_____

Patient Personal Information

First Name: _____ MI:____ Last Name:_____
Date of Birth _____/_____/_____ Age:_____ Social Security #:_____
E-Mail: _____

Male/Female: □ M □ F Marital Status: □ Single □ Married □ Divorced □ Widowed

Street Address:_____ Apt #: _____
City: _____ State:_____ Zip: _____
Phone #: Home: _____ Work: _____
Mobile: _____ Other: _____

Employment Status: □ Employed □ Disabled □ Retired □ Part-Time □ Not Employed □ Student □ Unknown

Medical Contact Information:

Primary Care Physician:_____ Phone Number: _____
Referring Physician:_____ Phone Number: _____
Pharmacy Name: _____ Phone Number: _____
Pharmacy Address: _____

Emergency Contact Information:

Name:_____ Relationship: _____
Daytime Phone #: _____ Evening Phone #: _____

Person With Whom We May Discuss Patient's Care *(if patient is a minor or medical decisions delegated to a guardian)*:
□ Same as above, or
Name:_____ Relationship: _____
Daytime Phone #: _____ Evening Phone #: _____

Meaningful Use Patient Demographic Data:

In compliance with the HITECH Act (EHR), to attain Meaningful Use we are required to capture demographic data including your preferred language, race and ethnicity. This is an important part of your medical history and will assist us during our clinical quality improvement process. *Please complete the information below:*

Preferred method of communication:
□ Home Phone: _____ □ E-mail
□ Work Phone: _____ □ Secure E-mail
□ Mobile Phone: _____ □ U.S. mail
□ Other Phone: _____

Ethnicity: □ Non-Hispanic or Latino □ Hispanic or Latino □ Prefer not to answer □ Unknown

Race: □ White □ Black/African American □ Hispanic □ American Indian or Alaskan Native □ Asian
□ Native Hawaiian/Other Pacific Islander □ Other □ Declined to Specify

Primary/Preferred Language: □ English □ Spanish □ French □ Chinese □ Korean □ Arabic
□ Other:_____

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Today's Date:_____/_____/_____

Patient Payment Information:

Person Responsible for Payment *(if different from patient)*:
Name: _____ Daytime Phone #: _____
Street Address:_____ Apt #: _____
City: _____ State:_____ Zip: _____
Relationship to Patient: □ Self □ Spouse □ Child □ Other:_____

Primary Medical Insurance
Insurance Company:_____
Policy #: _____ Group #: _____
Policy Holder's Name *(if different from patient):*_____
Policy Holder's DOB **(*Required)**: _____/_____/_____ Policy Holder's SSN:_____
Relationship to Patient: □ Self □ Spouse □ Child □ Other:_____

Secondary Medical Insurance
Insurance Company:_____
Policy #: _____ Group #: _____
Policy Holder's Name *(if different from patient):*_____
Policy Holder's DOB **(*Required)**: _____/_____/_____ Policy Holder's SSN:_____
Relationship to Patient: □ Self □ Spouse □ Child □ Other:_____

Do you have a Health Savings Account (HSA)? _____

How did you hear about us?

□ Doctor Referral *(please identify)*: _____
□ Insurance □ Friend/Family □ Yellow Pages □ Yelp □ ZocDoc □ Our website
□ Other Internet site: _____
□ Social Media: _____
□ Other: _____

Our physicians and other providers are expert in COSMETIC DERMATOLOGY as well as medical dermatology. Please review the accompanying questionnaire and let us know if you are interested in any of our services. Thanks!

The above information is accurate and complete to the best of my knowledge.

_____ _____
Date Signed **Signature of Patient or Patient's Representative**
Name (please print):_____

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