CENTRAL DERMATOLOGY CENTER

(Please print legibly, and complete all fields)

Patient Name_____
Last First Middle

Address_____
Street & Apartment # City State Zip

Home Phone (____) ____- _____ **Cell** (____) ____- _____ **Work** (____) ____-_____
(Please circle preferred contact method)

Email _____@_____

Date of Birth ____/_____/_____ **Age** _____ **SS#** _____-___-_____ **Gender**_____
Marital Status: Single Married Divorced Separated Widow/er

Ethnicity: Hispanic Non-Hispanic **Preferred language**_____
Race: Black / White / Asian / American Indian / Alaska Native / Native Hawaiian / Pacific Islander / Mixed Race / Other

Patient's Employer (if applicable)_____

Emergency Contact _____ **Relationship** _____
Name
Emergency Contact: Home/Cell Phone _____ **Work Phone** _____

Primary Care Physician _____
Please list both FIRST and LAST name, if possible.

Do you participate in any of the following? (Please circle) **Yelp Google Yahoo Angie's List**

How did you hear about Central Dermatology Center? (Please circle)

Physician (please specify) _____

Friend/Family **CDC Website** **Other**_____

Primary Health Insurance Company _____
Policy/ID # _____ **Group/ Plan #** _____
Policy Holder Name: _____ **Policy Holder DOB:** _____

Secondary Health Insurance Company _____
Policy/ID # _____ **Group/ Plan #** _____
Policy Holder Name: _____ **Policy Holder DOB:** _____

I understand that office visit charges are payable on the day the service is rendered. I authorize Central Dermatology Center to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Central Dermatology Center and myself.

Signature _____ **Date** _____