WELCOME TO OUR OFFICE

TODAY'S DATE______________________

REFERRED BY________________________

IN ORDER TO SERVE YOU PROPERLY, WE NEED THE FOLLOWING INFORMATION.
ALL INFORMATION IS STRICTLY CONFIDENTIAL.

PATIENT'S NAME ____
(Last) (First) (Middle)

BIRTHDATE________________________________ MARITAL STATUS ______________________________
(Month, Date, Year)

ADDRESS ____ZIP CODE ___________
(Street) (City)

HOME PHONE ( ) ___________________________ **WORK PHONE** ( ) ___________________________

CELL PHONE ( ) ___________________________ **E-MAIL**________________________________

RACE (Please circle): WHITE AMERICAN INDIAN OR ALASKA NATIVE ASIAN BLACK OR AFRICAN-AMERICAN NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER OTHER RACE

ETHNICITY (Please circle): HISPANIC OR LATINO NOT HISPANIC OR LATINO

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD AT TIME OF CHECK IN)

PRIMARY INSURANCE NAME: ____________________ POLICY HOLDER NAME: ______________________________

POLICY HOLDER DATE OF BIRTH: _________________ RELATIONSHIP TO PATIENT: ___________________________

I hereby authorize medical providers and personnel of Northshore Dermatology Center to contact me regarding appointments, lab and pathology results, surgical information and billing.

DISCLOSE **MEDICAL** INFORMATION ON (**PLEASE CIRCLE**):

VOICE MAIL ______________________________ YES NO
(Phone number)

E-MAIL ______________________________ YES NO
(if different from e-mail listed above)

It is the responsibility of the patient to contact us with any changes to the above information in writing.

PLEASE SIGN. THANK YOU.

SIGNED: ____**DATE:**_______________
(if you are not the patient, please specify your relationship to the patient)