ATLANTA CENTER FOR DERMATOLOGIC DISEASES, PC

PATIENT ID# **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 _____ **Cell Phone** _____ **Work Phone** _____

Preferred Contact: ☐Home ☐ Work ☐Cell **E-mail** _____

Any restrictions for contacting you, such as email or phone reminder? ☐ No ☐ Yes **If yes, please describe**

Emergency Contact _____ **Relationship to Patient** _____

Home Phone **Work Phone** **Cell Phone**

Patient's Employer _____ **Occupation** _____

Patient Race: _____ **Patient Ethnicity: (please circle one)** **Hispanic or Non-Hispanic** **Patient Language:** _____

Referring Physician Information:

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

Primary Ins. _____

Primary Insured: Name _____ **DOB** _____

Relationship to the insured? ☐Self ☐Child ☐Spouse ☐Other _____

Secondary Ins. _____

Secondary Insured: Name **DOB**

Relationship to the insured? ☐Self ☐Child ☐Spouse ☐Other

Pharmacy Name _____ **Pharmacy Phone #** _____

Pharmacy Location

I consent to have messages regarding test results/treatment left on the following (list phone numbers):

Home:_____**Cell:**_____ **Other:**_____

I consent to have test results/treatment discussed with:_____**Relationship:**_____

I understand my records may be sent to my referring physician or a physician that our health care staff deems necessary in the continuation of my health care.

Patient Signature: _____

Print Name of Parent or Legal Guardian: _____

Signature of Legal Guardian: _____

Date: