CAPITAL DISTRICT DERMATOLOGY PATIENT REGISTRATION FORM

Date:_____

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME:_____ MI:_____

Street Address:_____

City:_____ State:_____ Zip code:_____

Home Phone: ( )_____ Work: ( )_____ Cell: ( )_____

Date of birth:_____ Marital Status: Single Married Divorced Other

Gender: _____ Social Security number:_____

If patient is a minor, please provide parent(s) name:_____

Email:_____

Emergency contact: _____ Relationship to Patient:_____

Emergency Number: ( )_____

Emergency contacts are to be used in case of in office emergencies: when the patient is in our office and unable to call on their own behalf, this is not a HIPAA release to give medical information to the contact provided.

Primary Care Physician:_____

Address: _____ Phone: ( )_____

Pharmacy: _____

Address: _____ Phone: ( )_____

By giving Capital District Dermatology your Primary Care and Referring Physicians names you are allowing us to send records and notes to them when needed for your care.

_____ _____

Signature of Patient/Guardian Date