MOUNTAIN LAUREL DERMATOLOGY

Patient Demographics

Revised 2024

Patient Name:_____
First Middle Last

Marital Status: [ ]Single [ ]Married [ ]Divorced [ ]Widowed [ ]Legally Separated [ ]Partner

SSN #:_____**Date of Birth**:_____ **Birth Sex**: [ ]M [ ]F

Preferred Language:_____ **Ethnicity**: [ ]Hispanic [ ]Not Hispanic

Race: [ ]American Indian/Alaskan Native [ ]Asian [ ]Black [ ]Pacific Islander [ ]White [ ]Other Race

Preferred Contact Method: [ ]Patient Portal [ ]Phone [ ]Email

Emergency Contact: Full Name:_____ Phone: _____

Spouse: Full Name: _____ Phone: _____

Caretaker: Full Name: _____ Phone: _____

	Select Preferred Phone	**Detailed Messages May Be Left?**
Home Phone: (_____) _____-_____	[ ]	Yes [ ] No [ ]
Cell Phone: (_____) _____-_____	[ ]	Yes [ ] No [ ]
Work Phone: (_____) _____-_____	[ ]	Yes [ ] No [ ]

Email:_____

Mailing Address: _____
Street & Apartment # City State/Zip

Seasonal Address:_____

Pharmacy & Address:_____

Primary Care Physician:_____

Referring Physician:_____

AUTHORIZATION: I hereby authorize Mountain Laurel Dermatology, PLLC, and/or its providers to provide medical treatment to the above-named patient. I also authorize them to release any information acquired in the course of treatment or examination to the appropriate insurance company(ies) or other physicians as needed. I acknowledge and consent to photos or digital images to be recorded for care purposes. MLD retains the rights to these images, but copies may be requested or accessed by me upon request. I recognize these images will be kept in a secure manner to protect my privacy. Images that identify me will only be released and/or used outside the practice upon written authorization from me or my legal representative. I acknowledge that I received and reviewed a copy of Mountain Laurel Dermatology's Notice of Privacy Practices.

Patient (Authorized Representative) Signature Date