MOUNTAIN LAUREL DERMATOLOGY

Patient Demographics

Revised 4/6/17

Patient Name:_____
First Middle Last

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated ☐Partner

Social Security #:_____**Date of Birth**:_____ **Gender**: ☐ 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: _____

Home Phone: (____) _____-_____ **Is it okay to leave a detailed message here?** ☐Yes ☐No

Cell Phone: (_____) _____-_____ **Is it okay to leave a detailed message here?** ☐Yes ☐No

Work Phone: (_____) _____-_____ **Is it okay to leave a detailed message here?** ☐Yes ☐No

***(Please circle or checkmark preferred phone contact # to use from the three above.)**

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 that I receive reviewed a copy of Mountain Laurel Dermatology's Notice of Privacy Practices.

Patient (Authorized Representative) Signature Date