Florida Dermatology AND SKIN CANCER CENTERS

NEW PATIENT INFORMATION FORM

NAME (LAST, FIRST, MIDDLE) _____ SS# _____ BIRTHDATE _____ SEX _____

LOCAL ADDRESS _____ SECONDARY/BILLING ADDRESS (IF APPLICABLE) _____

CITY, STATE, ZIP _____ EMAIL ADDRESS _____ CITY, STATE, ZIP _____

MARITAL STATUS _____ HOME PHONE _____ CELL PHONE _____ PRIMARY CARE DOCTOR _____

ETHNICITY _____ **CIRCLE ONE:** *HISPANIC/LATINO DESCENT* *NON-HISPANIC/LATINO DESCENT* *DECLINES RESPONSE*

PREFERRED LANGUAGE _____ **HOW DID YOU FIND OUT ABOUT US:**_____

EMPLOYER INFORMATION

PRIMARY EMPLOYER _____

ADDRESS _____

CITY, STATE, ZIP _____

WORK PHONE _____

EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT? _____

NAME _____

RELATIONSHIP TO PATIENT _____

PHONE _____

RESPONSIBILITY PARTY INFORMATION (IF DIFFERENT FROM ABOVE)

NAME (LAST, FIRST, MIDDLE) _____ SS# _____ BIRTHDATE _____ SEX _____

LOCAL ADDRESS _____ SECONDARY/BILLING ADDRESS (IF APPLICABLE) _____

CITY, STATE, ZIP _____ EMAIL ADDRESS _____ CITY, STATE, ZIP _____

MARITAL STATUS _____ HOME PHONE _____ CELL PHONE _____ RELATIONSHIP TO PATIENT _____

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH FAMILY?

YES NO _____

IF YES, AND CONTACT PERSON IS DIFFERENT FROM ABOVE, PLEASE PROVIDE THEIR NAME & INFORMATION

NAME _____ PHONE _____ RELATIONSHIP TO PATIENT _____

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR ANSWERING MACHINE OR VOICE MAIL?_____

MAY WE MAIL OR EMAIL PERSONAL MEDICAL INFORMATION TO YOU?_____

PATIENT/GUARDIAN SIGNATURE _____ DATE _____