The Dermatology Clinic of South Florida, PA

Patient Information

Welcome! Thank you for choosing our office. Please help us serve you better by taking a few minutes to provide the following information. All information will be confidential. Please print.

First Name________________________ MI_____ Last Name______________________________

Preferred name to be called____

Date________________ SS#____________________ Date of Birth________________________

Circle: Male/Female Minor/Single/Married/Separated/Divorced/Widowed Employed/Retired/Student

FLORIDA

Home Phone______________________________ Cell Phone ______________________________

Address ____

City ____ State __________ Zip _______________

OTHER (if applicable)

Home Phone________________________ Address_______________________________________

City ____ State __________ Zip _______________

Employer_______________________________________ Occupation________________________

Work Phone____________________________ E-mail_____________________________________

If student, name of school____

Name of emergency contact_________________________________ Phone__________________

Referred by ☐Physician____________________________ ☐Friend_________________________

☐Family _________________________________ ☐Phonebook ☐Newspaper ☐Internet ☐Insurance

INSURANCE INFORMATION

	Primary	**Secondary**
Insurance Company	________________________	________________________
Policy Holder	________________________	________________________
Relation to patient	☐Self ☐Spouse ☐Parent	
Date of Birth	________________________	________________________
SS#	________________________	________________________
Policy ID#	________________________	________________________
Group #	________________________	________________________

FOR MINORS ONLY

________________________	________________________
Father's Name	Mother's Name
Father's Date of Birth SS#	Mother's Date of Birth SS#
Home Phone Work Phone	Home Phone Work Phone
Employer	Employer