NEW PATIENT REGISTRATION FORM

PREFERRED PHARMACY (FOR ELECTRONIC PRESCRIBING)

Name and Location_____

PRIMARY CARE DOCTOR: _____

PATIENT INFORMATION

Name (Last, First)_____Date of Birth: _____SEX: M____ F____
Address _____City _____ State_____ Zip _____
Preferred phone for contact: _____ Alternate phone: _____
E-mail _____ Marital Status: Single____ Married____ Divorced____ Widowed____
Preferred Language (circle): English Other:_____
Ethnicity (required): ___Hispanic or Latino ___Not Hispanic or Latino ___Unknown ___Declined to Specify
Race (required): ___ American Indian or Alaska Native ___Asian ___Black or African American ___White
___Native Hawaiian or Other Pacific Islander ___Other Race ___Declined to Specify

PARENT OR RESPONSIBLE PARTY (If different from patient. Must be completed for patients under age 18.

Name of Responsible Party (Last, First)_____Date of Birth:_____
Patient Relationship to the Responsible Party (Circle one): SELF SPOUSE CHILD OTHER
Address _____City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Cell Phone _____

How did you hear about us? (Please circle) Friend/Family Doctor's Office Facebook
Internet Search Newspaper Billboard Radio Other_____

Would you like to be included on our mailing list for our monthly newsletter? This will keep you up-to-date on new services in the office, provide cosmetic discounts, and offer helpful skin care advice.

PLEASE CIRCLE ONE: YES NO

*If yes, please provide your email address:_____

Premier Dermatology, Ltd.