Date: _____

COLUMBIA SKIN CLINIC

Patient Registration

(PLEASE PRINT)

Name: _____
*Last Name* *First Name* *Middle Initial* *Preferred Name*

Address: _____
*City* *State* *Zip Code*

Home Phone: _(____)_____ Cell Phone: _(____)_____ Work Phone: _(____)_____

Sex: _____ Date of Birth: _____ Age: _____ SSN: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed

**Email Address** (*for patient portal*): _____

Preferred Language: _____

**EMERGENCY CONTACT**

Name: _____ Relationship: _____ Phone: __(___)__ _____

Who may we thank for referring you?

□ Doctor (name: _____) □ Family: _____ □ Other: _____

**RESPONSIBLE PARTY** (if under 18): _____ Relationship to Patient: _____

Responsible Party SSN: _____ Responsible Party Date of Birth: _____

**INSURANCE INFORMATION**

Primary Insurance: _____ Policy Number: _____

Subscriber Name: _____ Date of Birth: _____ SSN: _____

Relationship to the Patient: _____

Secondary Insurance: _____ Policy Number: _____

Subscriber Name: _____ Date of Birth: _____ SSN: _____

Relationship to the Patient: _____

**Thank you for choosing Columbia Skin Clinic for your dermatology needs!**

*Rev 10/18*