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 Assigned at Birth: ____________ Preferred Gender Identity: ______________

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 [illegible]

www.columbiaskinclinic.com