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 09/2025