DERMATOLOGY & SKIN SURGERY CENTER OF PRINCETON **Today's Date:**

Prefix Mr. Mrs. Miss Ms. Dr. Preferred Name:

Patient's Name

First Middle Last

Address

Street & Apt # City State Zip

SS# Birthdate Age: Sex: ❑ Female ❑Male

Marital Status ❑ Single ❑ Married to: ❑ Other:

Home Phone Cell Phone Other Phone

Preferred Contact: ❑Home ❑ Work ❑Cell ❑Email ❑Text

Any restrictions for contacting you or leaving a message? ❑No ❑ Yes If yes, please describe

May we discuss your medical condition with any member of your household? ❒ No ❒ Yes
Please list any restrictions, if applicable: _____

May we text you for appointment confirmations? ❑No ❑ Yes

Work Phone Ext: Is it okay to call you at work? ❑ Yes ❑ No

Emergency Contact: Relationship to Patient: Phone#:

Patient's Employer Occupation

DEMOGRAPHICS (REQUIRED FOR SUBMISSION OF INSURANCE CLAIMS)

Ethnicity: ❑Hispanic ❑Non-Hispanic **Language:**

Race: ❑African-American ❑Asian ❑ American Indian/Native Alaskan ❑Native Hawaiian or Other Pacific Islander ❑White

How did you hear about us? ❑ Friend ❑ Insurance ❑ Internet ❑ Other Details:

Referring Dr.: Primary Care Dr.:

INSURANCE INFORMATION

Primary Ins. ID # Group #

Insured: Name DOB SS#

Relationship to the insured? ❑Self ❑Child ❑Spouse ❑Other

Secondary Ins. ID # Group #

Insured: Name DOB SS#

Relationship to the insured? ❑Self ❑Child ❑Spouse ❑Other

MEDICAL INFORMATION

Preferred Pharmacy: **Phone:**

Street Name/City/St/Zip:

EMAIL ADDRESS (PLEASE NOTE: WE ARE REQUIRED TO KEEP THIS ON FILE)

Email:

❒ Ok to contact me by email **❒ Not ok to contact me by email**