PATIENT INFORMATION

Dermatology & Skin Surgery Center

210 Village Center Pkwy
Stockbridge, GA 30281
www.dermandskin.com
(770) 474-5952

Name ____ Date ______________
Last *First* *M.I.*

Date of Birth _____/_____/_____ SS# ____________________ Gender ______________

Mailing Address ____
Street *City* *State* *Zip*

Cell ________________ Home ________________ Work ________________

E-mail ______________________ Would you like to receive email notifications? *YES or NO*

Race/Ethnicity *(Optional)* ☐ White/Caucasion ☐ Black/African American ☐ Hispanic/Latino ☐ Other __________

INSURANCE INFORMATION (Please present Insurance card and ID at time of check in)

Primary		***Secondary***	
Insurance Name	____________	Insurance Name	____________
Name of Insured	____________	Name of Insured	____________
Date of Birth	____________	Date of Birth	____________
Insurance ID#	____________	Insurance ID#	____________
Group #	____________	Group #	____________
Relationship to Patient	____________	Relationship to Patient	____________

Pharmacy ________________________________ Phone ______________

Pharmacy Address ____

In case of Emergency, please notify ______________________ Phone ______________

Who may we thank for referring you? ______________________________

Primary Care Physician ______________________________