REN Dermatology & LASER CENTER

Referred by: Physician:_____________ Friend/Family:_______ Social Media:_________ Other: _______

Legal Name: First ____________________________________ Name: __________________________

Date of Birth: ___________/__________/____________

Mailing Address: ____

City: ____ **State:**_____________ **Zip:** ______________

Email: ____

Social Security *(required for Insurance billing proposes)*: ___________ - ___________ - _____

Gender: Male_______ Female____________

Home Phone #: (_____)_______-________ Cell #: (_____) _______-________

Work #: (_____) _______-________

Emergency Contact

Name: _________________________________ **Relationship:** __________________

Phone #: (_____) _______-______

If under 18 Years Old

Guardian's Name *(required)*: ____

Relationship to Patient: ____

Contact Phone #: (__) ____________ - ___________

Address *(if different from above)*: ____

Insurance Responsible Party

Primary Insurance: ____________________________ Policy #________________________________

Primary Policyholder Name (as written by insurance):___________________________________

Primary Policyholder Date of Birth: __________ /__________ /__________

Relationship to Patient: ______________________________

By signing below, I acknowledge that I have read and understand the above information is correct to the best of my knowledge. *(If you are younger than 18 years old, forms must be signed by a parent or guardian.)*

Signature: ____________________________________ **Date:** _______ /________ /________