REN Dermatology
& LASER CENTER

Patient Information

Referred by: Physician:________ Friend/Family:________ Social Media:_________ Other: ________

Legal Name: **First:** ____ **Last:** ________________________________

Date of Birth: __________/_________/___________

Gender: **Male**___________ **Female**________

Mailing Address: ____

City: ____ **State:**_________________ **Zip**: __________________

Email: ____

Social Security *(Required for Insurance Billing)*: ___________ - _____________ - _____________

Home Phone #: (________) ______________-_______________ **Cell #: (________) ______________-______________**

Emergency Contact

Name: ________________________________ **Relationship:** _________________ **Phone #: (_____) ______________-______________**

Treatment of Minor *(Required for Minor Treatment Only)*

Guarantor's Name: ____

Relationship to Patient: _______________________________________

Contact Phone #: (______) ______________ - ______________

Address *(If different from above)*: ____

Insurance Responsible Party

Primary Insurance: ____

Primary Policyholder Name *(As written by Insurance)*:____

Primary Policyholder Date of Birth: _________ /_________ /_________

Relationship to Patient: _______________________________