REN Dermatology & LASER CENTER

PATIENT DEMOGRAPHICS

Legal First Name: _____ **Legal Last Name:** _____

Date of Birth: _____/_____/_____

Male: _____ **Female:** _____ **Other**: _____

Mailing Address: _____

City: _____ **State:** _____**Zip**: _____

Email: _____

Social Security *(required for insurance and billing purposes)*: _____-_____-_____

Home Phone: (_____**)** _____-_____ **Cell Phone: (**_____**)** _____-_____

EMERGENCY CONTACT

Name: _____ **Relationship:** _____ **Phone #: (**_____**)** _____-_____

Name: _____ **Relationship:** _____ **Phone #: (**_____**)** _____-_____

INSURANCE POLICY HOLDER INFORMATION

Insurance Carrier: _____

Primary Policyholder Name *(as written on insurance card)*:_____

Primary Policyholder Date of Birth: _____/_____/_____

Relationship to Patient: _____

PRIMARY CARE PROVIDER

Provider's Name: _____ ***Phone:*** (_____) _____-_____

Practice Name: _____ **Fax*:*** (_____) _____-_____

How did you hear about us? Physician: _____Friend/Family: _____ Social Media:_____Other: _____