

## **PATIENT DEMOGRAPHICS**



## PLEASE RETURN TO CHECK-IN ALONG WITH YOUR INSURANCE CARDS

PATIENT NAME			
Patient DOB		Patient SS#	
Address			
City	State		Zip
Home Phone	Work Phone		Cell phone
Email Address			
Employer		Employer Phon	e
RESPONSIBLE PARTY (If different than patient)			
Name		Relationship to patient	
DOB		SS#	
Address			
City	State		Zip
Home Phone	_ Work Phone		Cell phone
PRIMARY INSURANCE			
Name of Policyholder		Relationship to Patie	ent
Policyholder's DOB		Policyholder's SS#	
Policyholder Employer			
SECONDARY INSURANCE			
Name of Policyholder		Relationship to	Patient
Policyholders DOB		Policyholder's SS#	
Policyholder Employer			
EMERGENCY CONTACT			
Name	Relatio	onship to Patient	
Home Phone	Work Phone		Cell phone
8333 N. Davis Highway · Pensacola, FL · 32514 850.474.8386			

M:\CBO\_PracMngrs\Department Form Standardization\Dermatology\Patient Demo. Form