Hendersonville DERMATOLOGY

UPDATE CONTACT INFO FORM

PATIENT INFORMATION

Patient: *First Name:* *MI:* *Last Name:*	**Date of Birth:**
Previous Last Name (if changing):	**Marital Status:** Single Married Widowed Divorced
Birth Sex: Female Male	**Gender Identity:** Female Male Transgender
Phone #'s: *Home:* **Preferred Phone:** *Cell:* *Work:*	
Mailing address:	**APT #:**
City:	**State:** **Zip Code:**
Email address:	Would you like to be added to our cosmetic/Aesthetic services E-mail list : Yes No

IN CASE OF EMERGENCY WHO WOULD YOU LIKE TO BE CONTACTED

Contact Full Name:	Relationship to patient:
Phone *Home:* *Cell:* *Work:*	

PARENT/GUARDIAN (REQUIRED IF PATIENT IS UNDER 21 YEARS)

NOTE: Per NC Law, Both Parents can be held responsible for medical bills for minors, a medical practice is **NOT** bound by any separation agreement, divorce or child support order.

Parent/Guardian: *First:* *MI:* *Last:*		
Phone #:	Date of Birth:	Address (If different):

PHI RELEASE:

Without consent, we can NOT share information regarding your medical care *(including family)*. Please list below anyone you would like to have this information.

Name:	Relation:	Phone:
Name:	Relation:	Phone:

Signature of Patient or Legal Guardian _____ Date _____

Witness Signature _____ Date _____