Hendersonville DERMATOLOGY

REGISTRATION FORM

PATIENT INFORMATION

Patient: First Name: MI: Last Name: | Date of Birth:

Birth Sex: ☐ Female ☐ Male | Gender Identity: ☐ Female ☐ Male ☐ Transgender

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced | Language Spoken: ☐ English ☐ Spanish ☐ Other

Ethnicity: ☐ Hispanic ☐ Not Hispanic ☐ Refused | Race: ☐ White ☐ Asian ☐ Black ☐ Hispanic ☐ Indian/Native ☐ Other ☐ Refused

Social Security #: | Phone #'s: Preferred Phone: Home: Cell: Work:

Is the patient covered by insurance? ☐ Yes ☐ No

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

Employer's Name: | Occupation:

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): ☐ Same as above