AFFILIATED
DERMATOLOGISTS

Patient Registration

Personal Information

Date: ___________________________

Name: ____

Last First Middle

Address: ____

Street City State Zip

Primary Phone Number: ___________________________ ☐ Home ☐ Cell

Secondary Phone Number (if applicable): ______________________________________

Birthdate: _________________

Email: ____

Emergency Contact Information

Name: ____

Relationship to Patient: ____

Phone: ____

Responsible Party (if under 18 years old)

Name: ____

Address: ____

Street City State Zip

Primary Phone Number: ______________________ Birthdate of Responsible Party: _____________

Race	Ethnicity	Language
☐ African American or Black	☐ Hispanic or Latino	☐ English
☐ Asian	☐ Non-Hispanic or Latino	☐ Chinese
☐ Caucasian	☐ Declined to Answer	☐ Spanish
☐ Native American		☐ Other
☐ Other		☐ Decline to Answer
☐ Decline to Answer		

Signature of Patient or Legal Representative / Date

Printed name of Legal Representative, if other than the patient / Relationship to Patient