



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): _____

Preferred contact method (check all that apply): Phone Text Email

Birthdate: _____

Email: _____

Emergency Contact Information

Name: _____

Relationship to Patient: _____

Phone: _____

Guarantor Information

Please select one of the following:

Check here if the PATIENT is financially responsible.

Check here if anyone OTHER THAN THE PATIENT is financially responsible, then please fill out the information below.

Name: _____

Address: _____

Street

City

State

Zip

Primary Phone Number: _____ Birthdate of Responsible Party: _____

Race	Ethnicity	Language
<input type="checkbox"/> African American or Black	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> English
<input type="checkbox"/> Asian	<input type="checkbox"/> Non-Hispanic or Latino	<input type="checkbox"/> Chinese
<input type="checkbox"/> Caucasian	<input type="checkbox"/> Declined to Answer	<input type="checkbox"/> Spanish
<input type="checkbox"/> Native American		<input type="checkbox"/> Other
<input type="checkbox"/> Other		<input type="checkbox"/> Decline to Answer
<input type="checkbox"/> Decline to Answer		

Signature of Patient or Legal Representative

/ Date

Printed name of Legal Representative, if other than the patient

/ Relationship to Patient