Family Dermatology of North Florida*

Today's date:			
Patient's last name: First: Middle:			Marital status (circle one) Single / Mar / Div / Sep / Wid
Date of Birth: / /	Birth Sex: ❑ M ❑ F	Gender Identity	Social Security No.:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		( )	( )

PATIENT INFORMATION

❑ Home Phone No: ( )	❑ Work Phone No: ( )	❑ Cell Phone No: ( )	Email Address:
X Check for preferred number to call first		**Would you give permission for text messages? ❑ yes ❑ No**	
Local Street Address:	City:	State:	ZIP Code:
Seasonal Street Address:	City:	State:	ZIP Code:
Occupation:	Employer :		
Name of Parent/Guardian (for Minor Patient) or Spouse:	Parent/Guardian/Spouse Phone No: ( )		
Parent/Guardian Address (if different)	City:	State:	ZIP Code:
Parent/Guardian/Spouse Employer:	Parent/Guardian/Spouse Employer address:	Parent/Guardian/Spouse Employer Phone No.: ( )	
Referred to practice by: ❑ Dr.	❑ Insurance Plan	❑ Web Site	❑ Family/Friend:
Name of Primary Care Provider:			

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Phone No.: ( )
Primary Insurance:	Group No:	Policy No:	
Secondary Insurance (If Any):	Group No:	Policy No:	

AUTHORIZATION FOR OTHER PERSON(S) TO RECEIVE OR DISCUSS MEDICAL RECORDS

Name:	relationship:	Phone no:
Name:	relationship:	Phone no:

An Authorization remains valid until it is effectively revoked in writing, or until renewal of this form.

Patient Signature/ Other Signature if Patient Unable to Sign (Print Name) Date

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* 1/20/2020 vers;9