Aesthetic Dermatology A

David L. Allyn, MD, FAAD
Board Certified Dermatologist
Training in
General Dermatology ● Mohs Micrographic Surgery ● Medical Aesthetics ● Laser Surgery

Patient Registration

Last Name	First Name		Middle Initial
Date of Birth	Age	Gender ☐Male ☐Female ☐Other Identifier	Social Security Number
If Minor, Accompanying Parent's Name	Relationship to Patient		Preferred Language

Address

Street	City/State	Zip Code

Patient Contact Information

Home	Mobile/Cell	Work

E-mail Address: ☐Personal ☐Business

Preferred Method of Contact:	(Please provide alternate contact number and/or mailing address, if any)

Required Patient Information

Employment Status:

- ☐ Full Time
- ☐ Part Time
- ☐ Retired
- ☐ Self Employed
- ☐ Unemployed
- ☐ Student

Marital Status:

- ☐ Single
- ☐ Married
  Spouse's Name _____
  Phone Number _____
  Employer _____
- ☐ Widowed
- ☐ Divorced

Race:

- ☐ American Indian or
- ☐ Alaska Native
- ☐ Asian
- ☐ Black/ African American
- ☐ More Than One Race
- ☐ Native Hawaiian/
- ☐ Other Pacific Islander
- ☐ White
- ☐ I choose not to specify

Ethnicity:

- ☐ Hispanic or Latino
- ☐ **Not** Hispanic or Latino
- ☐ I choose not to specify

Patient's Employer / Phone Number / Patient's Occupation:

Insurance Information

Insurance Company Name (Primary)		Insurance Company Name (Secondary)	
ID Number	Group Number	ID Number	Group Number
Name of Policy Holder		Name of Policy Holder	
Insured's Name (if different from Policy Holder)		Insured's Name (if different from Policy Holder)	
Date of Birth of Holder	Social Security Number of Holder	Date of Birth of Holder	Social Security Number of Holder

Referring Provider Information

Primary Care Provider (PCP) / Location:	Did they refer you?

If not, how did you find us?

Patient Signature (Parent or Legal Guardian, if minor): _____

Print Name: _____ Date: _____