LAKEPORT DERMATOLOGY

REGISTRATION INFORMATION
Patient Contact Preferences

PATIENT INFORMATION					
LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #	
MAILING ADDRESS	CITY		STATE	SEX:	☐ MALE ☐ FEMALE
SPOUSE'S NAME	HOME #		WORK #		
EMAIL ADDRESS	MOBILE #		MARTIAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED		
RESPONSIBLE PARTY INFORMATION (If other than self)					
LAST NAME	FIRST NAME	MI	HOME #		
ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #	
EMPLOYER	OCCUPATION		WORK #		
EMPLOYER'S ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY ☐ SPOUSE ☐ SON ☐ DAUGHTER	
EMERGENCY INFORMATION - 1					
NAME	RELATIONSHIP		HOME #		
ADDRESS			WORK #		
CITY	STATE	ZIP			
PRIMARY CARE PHYSICIAN NAME					

☐Home Phone: It's ok to leave a message
☐Cell Phone: It's ok to leave a message
☐Work Phone: It's ok to leave a message
☐Home Address: It's okay to send written communication

Email: ____

Do you give the office of Lake Dermatology Medical Associates permission to discuss your medical information with family members?
☐YES ☐NO If Yes, Which Family Member(s)? ____

X ____________________________________
Signature