Triangle Dermatology Associates PA

Dr. Mr. Mrs. Ms. _____
First Middle Last

Address: _____

_____Zip_____

If patient is under 18 years old: Parent or Guardian's name (and address if different from above):

_____

Patient Social Security Number: _____

Gender at birth:_____ I identify my gender as: _____

Patient Date of Birth: _____

Circle one: Single Married Partnered Other

Spouse/Partner: _____

****Emergency contact information: _____**
First Name Last Name

Relationship:_____

Home Phone:_____ Work phone:_____ext. _____

**** Contact Information: (We require a phone number as a method of contact for you.)**

Your home phone:_____ Work Phone:_____ext._____

Your cell phone:_____

Your preferred method of contact:_____

Please provide your email address below. We will only use it to remind you of appointments:

_____

***Your Employment/Student Status: (circle one)**

Employed: Full time or Part-time Student: Full time or part time

Occupation:_____

Employer:_____

*** Primary Care Physician and Address: _____**
(We may share results with your primary care physician unless you specify otherwise.)

Race: (circle one) Caucasian African American Asian Other: _____

Ethnicity: (circle one) Hispanic Non-Hispanic Other:_____

Language:_____