CHAPEL HILL DERMATOLOGY

Patient Information

Patient's Name _____ **Chart Number** _____ **Sex:** Male or Female
Last Name First Name MI

Birthdate _____ **Place of Birth** _____ **Age** _____ **Marital Status** _____

Street Address _____
Street City State ZIP Code

Home Phone ( ) _____ **Work Phone** ( ) _____ **Cell Phone** ( ) _____

Employer _____ **Occupation** _____ **Preferred Contact** ☐ Cell ☐ Home ☐ Work

Work Address _____
Street City State ZIP Code

Preferred Language
- ☐ English
- ☐ Spanish
- ☐ Other
- ☐ I'd rather not report

Ethnic Origin
- ☐ Hispanic / Latino
- ☐ Not Hispanic / Latino
- ☐ I'd rather not report

Race
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic Origin
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other
- ☐ I'd rather not report

Social Security Number _____

Email Address _____

Guarantor Information (For Patients Under Age 18) and Billing Information

Guarantor's Name _____ **Relationship** _____
Last Name First Name MI

Birthdate _____ **Age** _____ **Sex** _____ **Marital Status** _____

Billing Address _____
Street City State ZIP Code

Insurance Information

Subscriber's Name _____ **Relationship** _____
Last Name First Name MI

Birthdate _____ **Sex** _____ **Social Security Number** _____

Street Address _____
Street City State ZIP Code

Employer _____ **Work Phone** ( ) _____

Work Address _____
Street City State ZIP Code

Emergency Contact

Contact's Name _____ **Phone** ( ) _____ **Relationship** _____

Authorization to File Insurance

I certify that all the above information is correct. I authorize the release of any information concerning my (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administrating claims for insurance benefits.

Signature _____ **Date** _____