NY Medical Skin Solutions
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TODAY'S DATE: ____________________

Patient Demographic Form
(PLEASE PRINT)

LAST NAME: ____________________ **FIRST NAME** ____________________ **MIDDLE INITIAL** ______

DATE OF BIRTH: ____________________ **AGE** ______ **SOCIAL SECURITY #** ____________________ ☐**MALE** ☐ **FEMALE**

Ethnicity: ______________ **Race:** ______________ **Religion:** ______________ **Language:** ______________

MARITAL STATUS ☐MARRIED ☐SINGLE ☐DIVORCED ☐ LIFE PARTNER ☐SEPARATED ☐WIDOWED ☐OTHER

HOME ADDRESS **APT#** **CITY** **STATE** **ZIP CODE**

____

HOME PHONE ______________ **WORK PHONE:** ______________ **OTHER** (☐ CELL ☐ FAX) ______________

EMAIL ADDRESS: ____________________

EMPLOYEMENT STATUS

☐ **ACTIVE DUTY MILITARY**	☐ **EMPLOYED-FULL TIME**	☐**NOT EMPLOYED**	☐ **STUDENT FULL-TIME**
☐ **CHILD**	☐ **EMPLOYED PART-TIME**	☐ **RETIRED**	☐ **STUDENT PART-TIME**
☐ **DISABLED**	☐ **HOMEMAKER**	☐ **SELF EMPLOYED**	☐ **OTHER**

EMPLOYER ____________________ **EMPLOYER PHONE#** ____________________

PRIMARY CARE PHYSICIAN/PHONE NUMBER

____

____

REFERRING PHYSICIAN/ADDRESS/PHONE NUMBER

____

____

HOW DID YOU HEAR ABOUT US?	☐ BILLBOARD	☐ FRIEND	☐MAGAZINE	☐ PHYSICIAN	☐ WEBSITE
	☐ EMPLOYER	☐ HEALTH FAIR EVENT	☐ MAIL	☐ RADIO	☐ YELLOW PAGES
☐ FAMILY MEMBER	☐ INSURANCE	☐ NEWS	☐ TELEVISION		☐ OTHER ______________

EMERGENCY/NEXT OF KIN CONTACT INFORMATION

LAST NAME ______________ **FIRST NAME** ______________ **RELATIONSHIP TO PATIENT** ______________

____

ADDRESS **APT#** **CITY** **STATE** **ZIP CODE**

HOME PHONE ______________ **WORK PHONE** ______________ **OTHER PHONE** (☐CELL ☐ FAX) ______________

INSURANCE INFORMATION

PLEASE PRESENT YOUR CURRENT INSURANCE CARD(S) AND ANY REFERRAL INFORMATION, IF APPLICABLE, TO THE RECEPTIONIST.

PRIMARY INSURANCE ____________________ INSURED ____________ ID# ____________________.

SECONDARY INSURANCE ____________________ INSURED ____________ ID# ____________________.