Skin Solutions
DERMATOLOGY

7 West 24th Street, 1st Floor, New York, NY 10010

Patient Information

Name _____ Date ___/___/___

Prefix *First* *M.I.* *Last* *Suffix*

Mailing Address _____

Apt *City* *State* *Zip*

Home Phone (___) _____ Work Phone (___) _____ Cell Phone (___) _____

Date of Birth ___/___/___ Age ____ Sex ____ Marital Status_____

SS# ___-___-___ Email _____ Occupation _____

Leave a message on your voicemail at work? □ Yes □ No Leave a message on your voicemail at home/cell? □ Yes □ No

Can we discuss your medical condition with another member of your household? □ Yes □ No

If so, whom? _____ Relationship _____ Phone (___) _____

Primary Insurance: _____ **ID#:** _____

Secondary insurance: _____ **ID#:** _____

Preferred Pharmacy: _____ **Address:** _____

Primary Care Physician:

Name: _____

Address: _____

_____

Phone: _____

Emergency Contact:

Name: _____

Relationship: _____

Home Phone: _____

Cell/Work Phone: _____

Receipt of Notice Privacy Practices
Written Acknowledgement (HIPAA)

I am a patient of Skin Solutions Dermatology, P.C., I hereby acknowledge receipt of Skin Solutions Dermatology, P.C.'s Notice of Privacy Practices.

Signature:_____ Date: _____

OR

As parent/legal guardian of the above, I hereby acknowledge receipt of Skin Solutions Dermatology, P.C.'s Notice of Privacy Practices.

Name (please print): _____

Relationship to patient: _____

Signature:_____ Date: _____