NEW PATIENT DEMOGRAHIC INFORMATION
TRIBECA PARK DERMATOLOGY

Patient Name:_____

Street Address:_____

City:_____State:_____Zip Code:_____

Telephone: (Cell)_____(Work)_____

Home (if different from Cell):_____Email address:_____

Date of Birth_____Last 4 Digits of SS.#:_____

Birth Sex: _____ Gender Identity: _____

Which best describes your race: (Please circle one)

American Indian *Hawaiian/Pacific Islander* Asian *White* *Black or African American* *Other*

Which best defines your ethnicity: (Please circle one)

Hispanic /Latino *Non- Hispanic /Latino* *Unknown*

Relationship Status: (Please circle one) *Single* *Married* *Partnered*

Name of Spouse/Partner:_____

Emergency Contact Name:_____Relationship:_____

Emergency Contact Phone Number: _

Name of employer:_____

Who referred you?_____

What is the name of your primary care physician?_____

What is the name of your Insurance Carrier? _____

Name of the primary policy holder (if other than self)?_____DOB?_____

Pharmacy:_____Address/Tel:_____

I understand that all medical costs incurred by me are my responsibility; including any charges my insurance fails to pay. I also understand that I am responsible for any collection and/or legal efforts that may be necessary on my account.

Signature of Patient:_____Date:_____

I authorize payment of medical benefits to the physician for services provided.

Signature of Patient/Insured:_____Date:_____

* Questions required by National Electronic Health Record Data Base