ROBBINS
Dermatology P.C.

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Patient Legal Name: _____
Last *First* *M.I.*

Preferred Name: _____ Marital Status: S M W D Sex: M F

Date of Birth: ____/____/_____ SSN: _____

Mailing Address: _____
City *State* *Zip*

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Language: (please circle one)
English Spanish Indian
Russian Other

Race: (please circle one)
White Asian American Indian/Alaska Native
Black/African American Hispanic Other

Ethnicity: (please circle one)
Hispanic or Latino Not Hispanic or Latino

E-Mail: _____
(*Providing your email will enable you to access our web portal.*)

Employer Name: _____

Responsible Party (if patient is a minor) *or Emergency Contact*

Name: _____ Date of Birth: ____/____/_____

Address: _____ Phone: _____

Insurance Policyholder Name, DOB, address: _____

_____

Preferred Pharmacy: _____

Payment Policy
You will be responsible for paying your annual deductible, co-payment and charges for any non-covered cosmetic services at the time of service. If you do not have medical insurance, payment is expected at the time of service unless other payment arrangements are made in advance.

_____ Date _____/_____/_____
Signature of patient or parent if patient is a minor