ORCHID
DERMATOLOGY

Patient Information

Patient Name:_____

Date of Birth:_____/_____/_____ Social Sec.#_____-_____-_____ Gender: Male Female

Primary Mailing Address: Street:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Primary Care Physician:_____

Referring Physician:_____

Pharmacy Information:

Name:_____ Address/Cross Road:_____

City:_____ Phone:_____

Parent, Spouse, or Responsible Party: ☐ check here is same as patient

Name:_____

Date of Birth:_____/_____/_____ Social Sec.#_____-_____-_____ Gender: Male Female

Mailing Address: Street:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____

Emergency Contact:

Name of Friend or Relative:_____

Relationship:_____ Phone Number:_____

I authorize Orchid Dermatology to contact me for appointment reminders, practice updates and informational promotions. ☐ **YES** ☐ **NO** Preferred method of contact: ☐ **PHONE** ☐ **EMAIL** ☐ **LETTER**

(We will never give out your email address or send personal medical information and bills via email.

Insurance Information:
Please present your insurance card(s) and a photo ID to the receptionist.
These will be copied and placed in your medical record for identification purpose and for protection of your Protected Health Information. Photo ID of parent/guardian requested for minor or if patient unable to consent.