Dermatology Practice of the Carolinas, PA

12611 N. Community House Road • Suite 102 • Charlotte, NC 28277
Tel (704) 544-8200 • Fax (704) 544-8300

CHART # _____

Patient Information

Name _____ Age _____ Date of Birth___/___/____

SS#_____-____-_____ Sex: M F Marital Status _____ Email _____

Mailing Address: _____

Phone: Home (____)_____-_____ Work (____)_____-_____ Cell (____)_____-_____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name of Insured _____ Relationship to patient_____

SS#_____-____-_____ Date of Birth (of insured) ____/____/_____

Mailing Address: _____

Phone: Home (____)_____-_____ Work (____)_____-_____ Cell (____)_____-_____

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance Name _____ Policy Holder's Name _____

SS #_____-____-_____ Birthdate: ____/____/_____

Group #_____ Contract # _____

Employer Name _____ Employer Phone_____

Relationship of patient to the Insured _____ **Do you have Secondary Insurance?_____

_____

PHARMACY INFORMATION

Preferred Pharmacy Name _____

Address and Phone Number_____

In case of Emergency, who should be notified (other than those already listed above)?

Name _____ Phone _____ Relationship _____

All of the above is correct to the best of my knowledge, and I agree to notify this office in a timely manner of any changes.

Patient or Responsible Party Signature _____ Date ___/___/20____