matherne
DERMATOLOGY + AESTHETICS

**Patient Demographic Form**

Patient Name: _____ Preferred Name: _____

Social Security #: _____ Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Status: Single____ Married____ Divorced____ Widowed____ Sex: Male____ Female____

Driver's License #: _____ Phone #: _____ Cell #: _____

Email Address: _____

Emergency Contact Name and Number: _____

Employed [ ] Yes [ ] No Retired [ ] Yes [ ] No

Patient Employer: _____

**Appointment reminders:** Please choose one

[ ] **TEXT** to cell phone number listed above [ ] **EMAIL** to email address listed above

[ ] **Phone** call to the number listed above

**Primary Insurance (please give your insurance card(s) to receptionist)**

Primary Insurance: _____ Subscriber's Name: _____

Subscriber's SSN: _____ Subscriber's DOB: _____

Patients relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Contract/Member ID#: _____ Group #: _____

**Secondary Insurance (please give your insurance card(s) to receptionist)**

Secondary Insurance: _____ Subscriber's Name: _____

Subscriber's SSN: _____ Subscriber's DOB: _____

Patients relationship to subscriber: [ ] Self [ ] Spouse [ ] Child

Contract/Member ID #: _____ Group #: _____

_____ _____

Print and signature of patient (if over 18) Date

_____ _____

Print and signature of guarantor (if patient is under 18) Relationship to patient