WESTCHESTER CENTER FOR DERMATOLOGY
NEW PATIENT REGISTRATION FORMS

PATIENT DEMOGRAPHICS	
Name	
Gender	
Date of birth (mm/dd/yyyy)	
Full Address	
E-mail Address	
Home Phone Number	
Cell Phone Number	
Alternate Number	
Social Security	
Race/Ethnicity	
Employment Status & Occupation	
Marital Status	
PRIMARY INSURANCE	
Does the Patient have health insurance?	
Primary Insurance Provider	
Policy ID Number & Group Number	
Is the Patient the policy holder?	
Relationship to Policy Holder	
Policy Holder's Name & D.O.B.	
Policy Holder's Gender	
Policy Holder's Social Security Number	
SECONDARY INSURANCE	
Does the Patient have secondary insurance?	
Secondary Insurance Provider	
Policy ID Number & Group Number	
Is the Patient the policy holder?	
Relationship to Policy Holder	
Policy Holder's Name & D.O.B.	
Policy Holder's Gender	
Policy Holder's Social Security Number	
	REFERRALS
Pharmacy Name and Telephone Number	
Referring Doctor Name and Telephone Num.	
EMERGENCY/ MEDICAL CONTACT	
Emergency Contact Name	
Emergency Contact Phone Number	
Emergency Contact Relationship	
PAST MEDICAL HISTORY	

Past and Current Medical Conditions	
Medication By Medical Condition	
Any Drug Allergies	
History of Melanoma/ Skin Cancer	
Last Full Body Exam	
Last Physical Exam	
Last Skin Biopsy	
FAMILY HISTORY	
Family Medical History	
SOCIAL HISTORY	
Tobacco Use Frequency	
Alcohol Intake Frequency	
SYMPTOMS	
Current Symptoms	
HOW DID YOU HEAR ABOUT US?	

**** PLEASE ALSO FORWARD A COPY OF YOUR INSURANCE CARD AND A PHOTO ID****