ONSPOT DERMATOLOGY

Last Name _____ First Name _____ MI ___

Date of Birth _____/_____/_____ Birth Sex - Male Female

SSN _____-_____-_____

Address _____

City_____ State _____ Zip _____

Home Phone _____ Cell _____

Preferred Phone for contact: Home Cell

Email Address _____

Marital Status: Single Married Divorced Widowed Separated

Prefered Language: English Spanish Other_____

Are you of Hispanic, Latino, or Spanish origin?

Yes_____(specify (e.g. Mexican, Puerto Rican, Cuban, etc.))

No _____(not Hispanic, Latino, or Spanish origin)

What is your race? Caucasian Asian Black/African American

Native Hawaiian OtherPacific Islander American Indian Alaska Native

Other:_____

Prefer not to answer

Authorization to Disclose Protected Health Information

Please list the individuals with whom we may discuss details of your medical care. Please give full name and relationship, and list any information you do not want shared:

_____

_____

_____

_____

Signature X _____ Date _____