2 Executive Park Drive, 2nd Floor Albany, NY 12203 518.482.8631 | albanyderm.com

PATIENT REGISTRATION FORM

Patient Name: First ____________________________ Last _____________________________ DOB: _____________

Address: ____

Telephone:

Home ( )______________________ Cell ( ) ______________________ Work ( ) _____________________

Primary Care Physician: ____

Address ____

Patient's Employer: ____

Address ____

Emergency Contact: ____ Relationship: ____________________

Telephone:

Home ( )______________________ Cell ( ) ______________________ Work ( ) _____________________

In order to comply with Federal requirements, we would appreciate if you would provide the following demographic information. Please circle or fill in your response. Please note that you may choose not to respond of any or all of these three questions.

Ethnicity:

- Non-Hispanic
- Hispanic
- Other: _______________________________
- I prefer not to respond

Race:

- Caucasian
- African American
- Asian
- Other: _____________________________
- I prefer not to respond

Preferred Language:

- English
- Other: _____________________________
- I prefer not to respond