

New Patient Registration Form

Laing Dermatology & Skin Cancer Center
 6807-C Knightdale Boulevard, Knightdale, NC 27545
 919-217-5510

Today's Date _____ Name you like to be called: _____

First Name:	Middle	Last	Suffix
Street Address:		Marital Status:	Married Divorced Single Widowed
City:	State:	Zip	Date of Birth: Age:
Social Security Number		E-Mail Address (This provides a way to contact you about scheduling or other issues)	
Home Phone		Cell Phone	Work Phone
Race (Required by Government)		Ethnicity _____	
Caucasion	African/American	Hispanic	Asian Other
		Primary Language Spoken	English Spanish Other
Name and Location of Pharmacy		Phone	
Name of Primary Care Physician		Phone	
Name of Previous Dermatologist			
Whom may we thank for referring you?:			
Friend/Relative (Name)		Yellow Pages	Insurance Ad Internet Other
Have you previously seen Dr. Laing? Yes No			
If yes, where have you seen her? _____			
When was the last time you saw her? _____			
Primary Insurance Plan Name:		Policy Holder's Name:	
Policy Holder's Social Security:			
Your(patient) Relationship to Policy Holder:		Policy Holder's Date of Birth:	
Secondary Insurance Plan Name:		Policy Holder's Name:	
Policy Holder's Social Security:			
Your(patient) Relationship to Policy Holder:		Policy Holder's Date of Birth:	

Signature of patient (or legal guardian, if a minor or incompetent)

IF PATIENT IS A MINOR, PLEASE COMPLETE THE SECTION BELOW:

Data provided below must be data of the parent/legal guardian authorizing & presenting minor for treatment

First	Middle	Last	Suffix
Street		Date of Birth	
City	State	Zip	Soc.Sec. No: