Blue Ridge Dermatology Associates, P.A.

3225 Blue Ridge Rd., Ste 101 Raleigh, NC 27612 • 155 Parkway Office Ct., Ste 204 Cary, NC 27518 • 919-781-1050

PLEASE PRINT

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

Mr. Mrs. Ms. Dr.

First	**Middle**	**Last**	**Suffix**

Street	**Marital Status:** M S D W	**Sex:** M F

City	**State**	**Zip**

Date of Birth:	**Age:**	**Social Security #**	
Home Phone #		**Work Phone #**	**Ext.**
Cell Phone #		**Email Address:**	

If College Student, Permanent Mailing Address:

Race (Please circle one): White Black/African American Asian American Indian or Native Alaskan Native Hawaiian/Pacific Islander

Ethnicity (Please circle one): Hispanic/Latino Non-Hispanic/Latino

Preferred Language (Please circle one): English Spanish Other: _____

Other Information

Name of Primary Care Physician:	**Phone:**
Name of Previous Dermatologist:	**Phone:**

Insurance Information

Primary Insurance Plan Name:	**Name of Employer Issuing Insurance:**
Policy Holders Name & Date of Birth:	**Patient Relationship to Policy Holder:**
Secondary Insurance Plan Name:	**Name of Employer Issuing Insurance:**
Policy Holders Name & Date of Birth:	**Patient Relationship to Policy Holder:**

Authorization to File Insurance

You herein authorize payment of medical benefits by your insurance carrier to the physician when an assigned claim is filed.
This authorization shall be valid until rescinded in writing or replaced by one at a later date.
(TO FILE INSURANCE, YOUR SIGNATURE IS REQUIRED BELOW)

Signature of patient (or legal guardian if a minor) **Date**

Parent/Guardian and/or Financially Responsible, If Applicable (if different from patient)

First	**Middle**	**Last**	**Suffix**

Street	**Date of Birth:**

City	**State**	**Zip**	**Social Security #**