



Patient Information

Name _____ Nicknames _____

Address _____ City _____ State _____ Zip _____

Mailing Address (if different) _____

Phone Number _____ Date of Birth _____ Age _____

Cell Phone Number _____ Social Security Number _____

Email _____

Place of Employment _____ Work Phone _____

Primary Care Physician _____ Address _____

Referring Physician _____ Address _____

Responsible Party (for minors only)

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Telephone _____ Social Security Number _____ Date of birth _____

Emergency Contact Information

Name _____ Phone Number _____

Cancelation/No Show Policy

Lake Dermatology asks that you kindly provide us 24 hours notice for any canceled appointments. We reserve the right to charge a failed visit fee of \$25 for any visit not canceled within 24 hours.

Signature _____

Date _____