Clayton Dermatology Group

Patient Registration Form

First Name: _____ **Middle:** _____ **Last:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Seasonal Address: _____

Home Phone: _____ **Cell:** _____ **Work:** _____

Email Address: _____ **Social Security Number:** _____

_____ **Male** _____ **Female** **Marital Status:** _____ **Date of Birth:** _____

Primary Physician: _____ **Phone:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Pharmacy Name: _____
Location: _____

Emergency Contact: _____
Phone: _____

Consent to Leave Detailed Message:

☐ **I consent** / ☐ **I do not consent** to have the physicians and/or staff of Clayton Dermatology Group to leave a detailed message on my voicemail or at my residence with the following individual(s).

Person: _____ Relationship: _____

Person: _____ Relationship: _____