Tara Dermatology Center
191 Medical Blvd - Stockbridge, GA 30281
Phone: (770) 991-1000 • Fax: (770) 991-2088

Patient Information

Name:(First, Middle, Last) _____ Date of Birth: _____

Address: _____ (City, State, Zip): _____

Social Security #: _____ Sex: ☐ M ☐ F Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Home Phone: _____ **Cell Phone:** _____ Work: _____ Preferred Name: _____

Race: _____ Employment Status: ☐ Employed ☐ Full-time Student ☐ Other _____

Parent/Gaurdian Information

Name _____ Date of Birth: _____

Address: _____

(City, State, Zip): _____

Social Security #: _____ Parent/ Gaurdian's Phone #: _____ Relationship to Patient: _____

Occupation: _____ Employer: _____ Employer Phone: _____

Spouse or Relative to Contact in Case of Emergency

Name _____ Phone: _____ Relationship to Patient: _____

Address: _____ (City, State, Zip): _____

Preferred Pharmacy Information

Name: _____ Phone: _____

Address: _____ (City, State, Zip): _____

Electronic Notification

Email (if you would like to be notified by email of upcoming appointments) _____

Cell (if you would like to be notified by text of upcoming appointments) _____ Mobile Provider _____

Insurance Information

Primary Insurance Name _____

Subscriber's Name _____

Subscriber's DOB _____

Group # _____

ID # _____

Secondary Insurance Name _____

Subscriber's Name _____

Subscriber's DOB _____

Group # _____

ID # _____

Referred By

Please fill out as much information as you can

Doctor's Name _____

Address or City _____

Phone # _____