The SKIN Revitalizing Center

WEST MICHIGAN DERMATOLOGY WWW.WESTMICHIGANDERM.COM

Your Home for Compassionate Service and Exceptional Care

NEW PATIENT REGISTRATION

PATIENT INFORMATION

Name: (Last, First) ____

Address 1: ____

Address 2: ____

City: ____________________________ State: ___________ Zip Code: _______________ Country: __________

Preferred Telephone: ____________________________ Secondary Telephone: __________________________

May we leave a detailed message? ☐ YES ☐ NO

Email Address: ____

Would you like to be added to our Skin Revitalizing Center monthly emails for product information and specials? ☐ YES ☐ NO

Date of Birth: ____________________(MM/DD/YYYY) Preferred Language: _______________________

Birth Sex: ☐ male ☐ female

Gender Identity: ☐ male ☐ female ☐prefer not to say ☐ something else

Race: ☐ White ☐ American Indian ☐ Asian ☐ Other ☐ Black or African American ☐ Native Hawaiian

Ethnic Group: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

I accept financial responsibility for any and all charges. Should my account ever become delinquent and an outside agency is used for collection, I understand an appropriate collection fee may be assessed.

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Patient or authorized representative signature **date**