# COSULICH DERMATOLOGY

**AUTUMN RIDGE**
**3350 Highway 138 West ◆ Building 2, Suite 122**
**Wall Township, NJ 07719**
Telephone ◆ 732−280−1200
Fax ◆ 732−280−1207
frontofficewall@cosulichdermatology.com

**THE COMMONS**
**1004 Commons Way ◆ Building G**
**Toms River, NJ 08753**
Telephone ◆ 732−349−6868
Fax ◆ 732−349−6022
frontofficetr@cosulichdermatology.com

## PATIENT DEMOGRAPHIC FORM

TODAY'S DATE:_____

Please complete this form to ensure proper billing of your services.

Name:_____ Date of Birth: _____
First Last

Age:_____Gender:_____Email (for your patient portal): _____

Street Address:_____ City, State, Zip:_____

Preferred Phone #: _____ ○ HOME ○ MOBILE Alternate Phone #:_____ ○ HOME ○ MOBILE ○ WORK

***Emergency Contact Information***

Emergency Contact Name:_____ Relationship to You: _____

Best Contact # for Emergencies: _____

***Primary Care Information***

Primary Care Physician: _____
Address (street): _____
City, State, Zip: _____
Telephone #: _____

Ref. Physician (if different): _____
Address (street): _____
City, State, Zip: _____
Telephone: _____

Send diagnostic letters to Primary/Referring Physician, if necessary?: ☐ Yes ☐ No

***Insurance Information***

Policy Holder's Name: _____

Your Relationship to Policy holder (or write SELF): _____

Policy Holder's Date of Birth: _____

**PRIMARY** Insurance Carrier: _____ **SECONDARY** Insurance Carrier: _____

Member ID #:_____ Member ID #: _____

COSULICH DERMATOLOGY, LLC

# PATIENT DEMOGRAPHIC FORM

***Electronic Communications***

**Patient Portal:** For your convenience, our practice offers secure electronic communications between you and your office via the Patient Portal. Secure messages and information can be read only by someone who knows your password to log in to the Portal site. The communications are automatically encrypted and, for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information.

☐ Yes, I want to participate using my email provided on Page 1.

☐ No, I do not wish to participate at this time and decline online access to my clinical notes, results, and the ability to exchange messages via the portal.

**Appointment Reminders:** As an added convenience, we offer appointment reminder phone calls and texts via an automated service. The reminders are sent using a software service and cannot be used as a way for you to communicate back to us. Should you need to reach us, please call our main number (732−280−1200). If at any time you change your mind about reminders, please let us know or simply opt out by following the prompts in the voice calls or texts.

I understand under the Telephone Consumer Protection Act, that in order for the practice to contact me for services related to my medical care, Cosulich Dermatology, LLC and/or its agents may contact me by phone, including my cell phone, which may result in charges to me. Methods of contact may include prerecorded/artificial voice messages and/or use of an automated dialing device, as applicable.

☐ Yes, I want to participate. Phone #: _____

☐ No, I do not wish to participate at this time and decline any reminders for my future appointments.

Patient Signature:_____Date: _____

***Additional Information***

Which category best describes your racial background?

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Unreported/Refuse to Report

Ethnicity: How would you describe your ethnicity, such as your family background or ancestry?

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unreported/Refuse to Report

Preferred language: What language do you usually speak at home?

☐ English ☐ Spanish ☐ Other _____

Whom can we thank for referring you to our practice?

☐ Health Insurance ☐ Social Media ☐ Google/Other Search Engine ☐ ER/Hospital/Doctor

☐ Newspaper/Magazine ☐ Other Patient _____ ☐ Other _____ _