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Demographic Sheet

Last Name _____ First Name _____ M.I. _____

Marital Status: *Single Married Divorced Widow Other* Social Sec # _____

Gender: *Male Female Other* _____ **Birth date:** _____

Address _____ City _____

State _____ Zip Code _____

E-mail: _____ Home Phone #: _____

Cell Phone #: _____ Work Phone #: _____

Please circle your preferred contact method: *Cell / Text Home Work*

Is it okay to leave a detailed message on your phone? *Yes No*

Emergency Contact: _____ Relation: _____ Phone # _____

Occupation _____ Employer _____

Primary Doctor (Internist or Family Doctor) Please Include **Name, City, and Phone #**

Whom may we thank for this referral? _____

The following three questions are requested by The U.S. Government:

Race (please circle): *Caucasian African-American American Indian Asian Other*

Ethnicity (please circle): *Latino (Hispanic) Non-Latino(Non-Hispanic) Other*

Circle your preferred language: *English Spanish Russian Sign Other* _____

Insurance: Name of primary insurance (e.g. BCBS, Medicare, etc.) _____

Name Secondary Insurance (leave blank if none) _____

Name of the primary policyholder? _____ Relationship to patient _____

Please hand all insurance cards to receptionist so that we may verify your eligibility