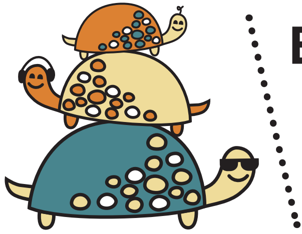

Burkhart Pediatric & Adolescent Dermatology

(919) 476-1118 | (855) 878-6037
135 Parkway Office Court - Suite 201
Cary, NC 27518
info@burkhartpediatricdermatology.com
www.burkhartpediatricdermatology.com

Patient Information Form

Date: ____________
Chart #: __________

Patient's Legal Name

First: ______________________________ MI: _____ Last: ____

Patient's Chosen Name: ___________________________ Date of Birth: _________ Gender: ____________

Patient's Preferred Pronouns: he/him/his ◯ she/her/hers ◯ they/them/theirs ◯ other:__________

Sex Assigned at Birth: ◯ Male ◯ Female ◯ Decline to State Preferred Language: ___________

Address: ____

City: ____ State: ____________ Zip Code: _____________

SSN: ____

Primary Phone: (_____) ______________________ Secondary Phone: (_____) ___________________

Parent/Legal Guardian 1

First: ______________________________ MI: _____ Last: ____________________________________

DOB: ______________________________ Email: ____

Address: ____

City: ____ State: ____________ Zip Code: __________

Primary Phone: (_____) _____________________ Secondary Phone: (_____) ________________

Parent/Legal Guardian 2

First: ______________________________ MI: _____ Last: ____________________________________

DOB: ______________________________ Email: ____

Address: ____

City: ____ State: ____________ Zip Code: __________

Primary Phone: (_____) _____________________ Secondary Phone: (_____) ________________

Continued

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Patient Information Form - page 2

Does the patient live with both legal guardians? ◯ Yes ◯ No

If not, what is the patient's living situation: ◯ Lives with adoptive parents ◯ Joint custody

◯ Single custody ◯ Lives with foster family

Primary E-mail Address(es) to Access the Secure Patient Portal: ______________________________

____

Current Primary Care Provider: Name: ____

Address:____ Phone: ______________

Preferred Pharmacy: Name: ____

Address:____ Phone: ______________

Insurance Information

Subscriber's Name: First: ___________________________ MI: _____ Last: ____________________

DOB: ___________________________

Subscriber's Address if Different from Patient: ______________________________________

Insurance Company Name:____

Member ID: __________________________________ Group Number:_________________________

Subscriber Information - Relationship to Patient: ____________________________________

Employer: _______________________________ Insurance Co. Phone: (____) ________________

Emergency Contact (other than Parent/Legal Guardian)

Name: ____ Phone: (____) ______________________

Relationship to Patient: ____