KEYSTONE DERMATOLOGY
& CENTER FOR SKIN SURGERY

Patient Questionnaire

Please fill out the following questionnaire neatly so that we can serve you better. Thank You!

Name: _____ DOB: _____ Social Security: _____

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino ☐ Other ☐ Decline to Specify

Race: ☐ White ☐ African American ☐ Other ☐ Decline to Specify

Smoking Status: ☐ Never Smoker ☐ Current Smoker ☐ Former Smoker

Check One: Male: _____ Female: _____ Identifies as: _____

Marital Status: Married ____ Single ____ Divorced____ Widowed____ Other____

Patient Current Address: _____

Home Phone: _____ Cell Phone: _____

Preferred Phone: Home ☐ or Cell ☐ Is it OK to leave a detailed message? _____

Email Address: _____

Emergency Contact Name and Phone Number: _____

Spouse Name and Phone Number: _____

Power of Attorney Name and Phone Number: _____

Primary Care Physician & Office Location: _____

For Children ONLY:

Guarantor Name (who receives bills for the child):_____

Guarantor DOB: _____

Guarantor Address (if different than address listed):_____