



Dermatology & Vein Institute

New Patient Registration

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Atlanta Dermatology, Vein & Research
11800 Atlantis Place
Alpharetta, Georgia 30022
770-360-8881
fax 770-255-2533

PATIENT

Name: _____ Date of Birth: _____
First Middle Last MM/DD/YY

Address: _____
Street City State Zip

Email Address: _____

Primary Phone: _____ Secondary Phone: _____ Soc. Sec #: _____
Include Area Code (xxx) xxx-xxxx Include area code (xxx) xxx-xxxx xxx-xx-xxxx

Nickname: _____ Prior Name: _____

Marital Status: Single Married Divorced Widowed Sex: Male Female

Employment Status: Employed Part-time Student Full-time Student Other

Occupation: _____ Employer: _____

Employer Address: _____
Street City State Zip

RESPONSIBLE PERSON (IF DIFFERENT FROM PATIENT)

Name: _____ Phone Number: _____ Relationship: _____
First Middle Last Include area code (xxx) xxx-xxxx

Address: _____
Street City State Zip

Phone Number: _____ Soc. Sec #: _____ Occupation: _____
Include area code (xxx) xxx-xxxx xxx-xx-xxxx

Employer: _____ Employer Phone Number: _____

SPOUSE

Name: _____ Date of Birth: _____
First Middle Last MM/DD/YY

Soc. Sec# : _____ Occupation: _____
xxx-xx-xxxx

Employer: _____ Employer Phone Number: _____

INSURANCE INFORMATION

Name of Insured: _____ Date of Birth: _____ Relationship: _____
First Middle Last MM/DD/YY

Insurance Company: _____ Group Number: _____ ID Number: _____

Claims Address: _____
Street City State Zip

EMERGENCY CONTACT

Name: _____ Phone Number: _____ Relationship: _____
First Middle Last Include area code (xxx) xxx-xxxx

Address: _____
Street City State Zip

How were you referred to our office?: By a Family Member By a Doctor By a Patient Other _____