DERMATOLOGY LTD
PATIENT REGISTRATION

Patient Name: _____ **Date of Birth:** _____

PLEASE CIRCLE
MR. / MRS. / MS. / OTHER

PLEASE CIRCLE
SINGLE / MARRIED / OTHER

PLEASE CIRCLE
EMPLOYED / STUDENT / RETIRED

SEX: MALE / FEMALE SEXUAL ORIENTATION: _____ GENDER IDENTITY: _____
RACE: _____ETHNICITY: _____ LANGUAGE: _____
HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____
STREET ADDRESS: _____
CITY: _____STATE:_____ZIP CODE: _____
EMAIL ADDRESS: _____
EMPLOYER'S / SCHOOL NAME: _____
OCCUPATION: _____

Preferred Method of Contact for reminder calls and other electronically generated messages ***(Select All That Apply)****:*

☐ **VOICE** ☐ **TEXT** ☐ **E-MAIL**

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ **PATIENT (Name):** _____ ☐ **PHYSICIAN (See Below)** ☐ **OTHER:** _____

RESPONSIBLE PARTY INFORMATION – PLEASE CIRCLE: PARENT SPOUSE GUARDIAN
NAME: _____SSN: _____
STREET ADDRESS: _____
CITY: _____STATE:_____ZIP CODE: _____

PRIMARY INSURANCE
INSURANCE COMPANY'S NAME: _____
SUBSCRIBER'S NAME: _____ DATE OF BIRTH: _____
RELATIONSHIP TO PATIENT: _____SSN: _____
ID#: _____GROUP#: _____

SECONDARY INSURANCE
INSURANCE COMPANY'S NAME: _____
SUBSCRIBER'S NAME: _____ DATE OF BIRTH: _____
RELATIONSHIP TO PATIENT: _____SSN: _____
ID#: _____GROUP#: _____

PRIMARY CARE PHYSICIAN
NAME: _____PHONE#: _____
ADDRESS: _____

REFERRING PHYSICIAN
NAME: _____PHONE#: _____
ADDRESS: _____

EMERGENCY CONTACT
NAME: _____PHONE#: _____
RELATIONSHIP: _____

ASSIGNMENT OF BENEFITS
I authorize the release of medical information necessary to process this claim and I also authorize payment of medical benefits to the physician. I am financially responsible for non-covered services, deductibles, and/ or co-payments.

Signature: _____ Date: _____