

**DERMATOLOGY, LTD.
PATIENT REGISTRATION**

DATE _____

NAME: _____
LAST FIRST M.I

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

PLEASE CIRCLE
SINGLE / MARRIED / OTHER

PLEASE CIRCLE
EMPLOYED / STUDENT / RETIRED

DATE OF BIRTH: _____ SEX: MALE / FEMALE
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: _____