

Dermatology Associates, LLC

PATIENT REGISTRATION FORM

TODAY'S DATE: _____

Demographics:	<input type="checkbox"/> New Patient	<input type="checkbox"/> Minor Patient	<input type="checkbox"/> Update
Patient's Name: _____	Date of Birth: _____	Age: _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Social Security #: _____	Marital Status: _____	Preferred form of address: <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss	
Mailing Address: _____	Home Phone#: _____	Cell Phone #: _____	
Residential Address: (if different from above) _____			
Winter Address: _____	Winter Phone #: _____		

In case of Emergency, whom should we notify? _____	Phone #: _____
Relationship to Patient: _____	

Name of Primary Care Physician: _____	Phone #: _____	
Address: _____	City: _____	State: _____
Did your Primary Care Physician refer you to this office?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, were you referred by another Physician? <input type="checkbox"/> No	<input type="checkbox"/> Yes	If yes, by whom? _____

Employment Information:		
Employer: _____	Work Phone #: _____	Occupation: _____
Employer's Address: _____		
Spouse's Information: (if applicable)		
Spouse's Name: _____	Work Phone #: _____	Occupation: _____

Insurance Information: Please present your insurance card(s) to the receptionist. The receptionist will make a copy and return them to you promptly.		
Primary Insurance Carrier Name: _____		
Certificate #: _____	Group #: _____	Phone #: _____
Name of Insured (Guarantor): _____	Date of Birth: _____	SSN #: _____
Insurance claims address: _____	City: _____	State/ZIP: _____
Secondary Insurance Carrier Name: _____		
Certificate # _____	Group #: _____	Phone #: _____
Name of Insured (Guarantor): _____	Date of Birth: _____	SSN #: _____
Insurance claims address: _____	City: _____	State/ZIP: _____

Release of Information Authorization:	
I hereby authorize release of MEDICAL INFORMATION necessary to process claims for services provided by the Medical Staff at Dermatology Associates. I also hereby authorize release of MEDICAL BENEFITS directly to Dermatology Associates. I understand that even though I have some type of insurance I am responsible for payment of services.	
Patient/Parent/ Legal Guardian Signature: _____	Date: _____

If patient is a Minor, please fill out the information below:

Contact Information:		
Mother's Name: _____	Father's Name: _____	
Address (if different from above): _____	Address (if different from above): _____	
Home Phone #: _____	Home Phone #: _____	
Work Phone #: _____	Cell Phone #: _____	Work Phone #: _____
Cell Phone #: _____		Cell Phone #: _____
Name of Employer: _____	Name of Employer: _____	
Financially Responsible Party Name: (after Insurance) _____		

Permission to treat a Minor: Many times parents find themselves unable to accompany their teen or young adult children to appointments. Your signature will give us permission to treat should you be unable to accompany your child. Permission is good for one year.	
I hereby give my permission to have my child treated when they arrive at the office unaccompanied.	
Parent/Legal Guardian: _____	Date _____