GEORGETOWN
DERMATOLOGISTS, P.C.

Christopher J. Remishofsky, MD
Jennifer Schaeff, PA-C, MMS

REGISTRATION INFORMATION

Today's Date: _____/_____/_____

Mr. Mrs. Ms. Dr. _____ _____ _____
Last name First name Middle name

Date of birth: _____/_____/_____ Age _____ Sex: M F Social Security #: _____

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____ _____
Primary Phone # (Home? Mobile? Office?) Alternate Phone # (Home? Mobile? Office?) E-mail address

_____ _____ [ ] Text [ ] Voice [ ] E-mail
Patient Employer Business Phone # Preferred Method of Contact

_____ _____/_____/_____ _____ _____
Responsible Party **(if different from above)** Date of Birth Social Security # Telephone #

_____ _____ _____
Responsible Party's Employer Business Phone # Responsible Party's Signature

_____
Name of Spouse/Guardian

How did you learn about our office? _____

Name of Primary Care Physician: _____

Names of other family members seen in our office: _____

INSURANCE & PAYMENT INFORMATION

_____ _____ _____ _____/_____/_____
Name of insurance carrier Group/Policy # Contract/ID # Subscriber's Date of Birth

Do you have a Health Savings Account (HSA/HRA) that you would like to use? [ ] Yes [ ] No

For all patients less than 18 years of age, a parent or guardian must sign:

I give my permission for Christopher J. Remishofsky, MD, Jennifer L. Schaeff, PA-C, and/or other medical professionals employed by Georgetown Dermatologists, PC, to examine and treat my child or dependent.

Parent/Guardian: _____

Please give your insurance card, photo ID, and any referral forms to the receptionist before the doctor examines you.