DERMATOLOGY ASSOCIATES, P.C.

PATIENT REGISTRATION FORM

PATIENT

Last Name: ____________________ Legal First Name: ____________________ Middle Initial: _____________

Preferred Name: ____________________ Birth Date: ____________ Age: _____ Gender: ___Female ___Male

Mailing Address: ____Apartment # ______

City: ______________________________ State: ________________________ Zip: ______________________

Please check your preferred phone number for contact.

__Home Phone: (___) _____-______ __Cell Phone: (___) _____-________ __Work Phone: (___) _____-______

E-mail: ____ Social Security: _____________________________

Employer: _______________________________________ Occupation: _________________________________

Employer Address: ____

Marital Status: Married___ Single___ Divorced___ Separated___ Widowed___ Domestic Partner___

RESPONSIBLE PARTY

Last Name: ____________________ Legal First Name: ____________________ Middle Initial: _____________

Relationship to Patient: _______________ Birth Date: ____________ Age: _____ Gender: ___Female ___Male

Mailing Address: ____Apartment # ______

City: ______________________________ State: ________________________ Zip: ______________________

Home Phone: (___) _____-________ Cell Phone: (___) _____-_________ Work Phone: (___) _____-________

E-mail: ____ Social Security: _____________________________

Employer: _______________________________________ Occupation: _________________________________

EMERGENCY CONTACT

Name: _______________________________ Relationship: ____________________ Phone: _______________

PLEASE COMPLETE BACK OF THIS FORM

Patient Primary Care Physician (PCP): ________________________________ Phone: (___) _____-________

Referring Physician (if different than PCP): _____________________________ Phone: (___) _____-________

PRIMARY INSURANCE INFORMATION

Name of Insured: ___________________________Birth Date: _________ Relationship to Insured: __________

Insurance Company: ____ Phone: (___) _____-________

Policy ID #: ________________________________ Group #: _____________________ Co-Pay $ _________

Does your Insurance Require a Referral? Yes ___ No ___

SECONDARY INSURANCE INFORMATION

Name of Insured: ___________________________Birth Date: _________ Relationship to Insured: __________

Insurance Company: ____ Phone: (___) _____-________

Policy ID #: ________________________________ Group #: _____________________ Co-Pay $ _________

Does your Insurance Require a Referral? Yes ___ No ___

AGREEMENT

I attest that the information I have provided to Dermatology Associates, P.C. is correct and true to the best of my knowledge. I hereby assign benefits to Dermatology Associates, P.C., and authorize them to furnish information regarding my medical condition to my insurance carrier or its intermediaries. ***I understand that I am responsible for any amount not paid by my insurance per the provisions of my policy. Furthermore, I understand that if payment is returned due to insufficient funds or my account is turned over to a collection agency for non-payment, a $35 fee will be assessed.*** *I have read and understand the financial policy and my signature below indicated I accept this policy and agree to abide by the terms for my treatment at Dermatology Associates, P.C.*

PATIENT OR RESPONSIBLE PARTY:

Printed Name: ____

Signature: ____ Date: __________________________

Relationship to Patient: _____________________________________

All patients are required to present State or Federal recognized photo ID and insurance card(s) to the receptionist so copies can be scanned into your medical record. Per Practice Policy, refusal to present photo ID or insurance card(s) can result in our rescheduling your appointment to another day.

Thank you.

Revised 07/20 TRM