

DERMATOLOGY ASSOCIATES, P.C.
PATIENT REGISTRATION FORM

PATIENT

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ Birth Date: _____ Age: _____ Gender: ___ Female ___ Male

Mailing Address: _____ Apartment # _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

E-mail: _____ Social Security: _____

Employer: _____ Occupation: _____

Marital Status: Married ___ Single ___ Divorced ___ Separated ___ Widowed ___

Ethnicity/Race: White ___ Hispanic/Latino ___ Black/African American ___ Asian ___

American Indian/Alaskan Native ___ Preferred Language: _____

RESPONSIBLE PARTY

Last Name: _____ 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:

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.