

**DERMATOLOGICAL CARE
PATIENT REGISTRATION FORM**

PATIENT

This section refers to the PATIENT ONLY (make corrections as necessary)

Name:	Sex:	Date of Birth:
Address:		
City, State, Zip:	SSN#:	
Home Phone:	Cell Phone:	
Employer:	Phone:	
Primary Care Physician:	Phone:	
Referred by:	Email:	

RESPONSIBLE PARTY

Review/complete if person responsible for the bills is NOT the PATIENT!

Name:	Relationship:	Sex:	Date of Birth:
Address:			
City, State, Zip:	SSN#:		
Home Phone:	Work Phone:	Employer:	

INSURANCE

Please list required information pertaining to your insurance coverage. If you have multiple coverage, supply information for both carriers

Pri Carrier:		Sec Carrier:	
Insured:		Insured:	
Date of Birth:	SSN#:	Date of Birth:	SSN#:
Patient Relationship:		Patient Relationship:	
Insured ID:		Insured ID:	
Group #:		Group #:	
Insurance Address:		Insurance Address:	
Copay:		Copay:	

PHONE CALLS

Do we have permission to:

Leave messages concerning your appointment, test results, and responses to patient phone calls?

Home phone: ☐ Yes ☐ No

Cell Phone: ☐ Yes ☐ No

Work phone: ☐ Yes ☐ No

Discuss your medical condition with a member of your household ☐ Y ☐ N

If yes, whom? (1) _____ Relationship: _____ Phone#: _____

(2) _____ Relationship: _____ Phone#: _____

AUTHORIZATION

I hereby give **Dermatological Care** my consent to any necessary medical evaluation and treatment. I hereby authorize release of information and/or photos between any of my treating physicians; to my insurance company to process my claim and authorize payment directly to **Dermatological Care**, benefits otherwise payable to me. I understand I am financially responsible for charges not paid in a timely manner by my insurance. The above information is correct to the best of my knowledge.

Signed: _____

Date: _____