

COMPREHENSIVE DERMATOLOGY CENTER

PATIENT REGISTRATION FORM

PATIENT NAME: _____ GENDER: M F DATE: _____
SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____
MARITAL STATUS: MARRIED DIVORCED SINGLE WIDOWED PARTNER
RESPONSIBLE PARTY IF PATIENT IS MINOR: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____
REFERRED BY: _____ PRIMARY DOCTOR: _____

PATIENT/RESPONSIBLE PARTY EMPLOYMENT INFORMATION

EMPLOYER: _____ OCCUPATION: _____
ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
WORK PHONE NUMBER: _____

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY: _____
POLICY NUMBER _____ GROUP NUMBER: _____
CLAIMS MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
POLICY HOLDER NAME: _____ M F (CIRCLE)
POLICY HOLDER DATE OF BIRTH: _____ SOCIAL SECURITY #: _____
PATIENTS RELATIONSHIP TO POLICY HOLDER: _____

SECONDARY INSURANCE INFORMATION (If any)

INSURANCE COMPANY: _____
POLICY NUMBER: _____ GROUP NUMBER: _____
CLAIMS MAILING ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____
POLICY HOLDER NAME: _____ M F (CIRCLE)
POLICY HOLDER DATE OF BIRTH: _____ SOCIAL SECURITY #: _____
PATIENTS RELATIONSHIP TO POLICY HOLDER: _____

DO WE HAVE YOUR PERMISSION TO:

Leave a message on your answering machine at home? Yes No
Leave a message at your work place? Yes No
Discuss your medical conditions with any member of your household? Yes No

IN CASE OF **Emergency**, WHO SHOULD BE CONTACTED ?

NAME: _____ PHONE: _____

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____