The Art and Science of Dermatology

Patient Registration Form - PLEASE USE BLACK INK ONLY

PATIENT INFORMATION **Referring Physician**____

Patient Name: Last____ First __________________________________ Middle _________________

Address ____ City___________________________State__________ Zip_______________

Sex: Male / Female Title: Dr. Mr. Mrs. Ms. Miss Social Security # ____ _____ ____ - ____ ____ - ____ ____ ____ ____

Birth date ______ - ______ - ______ Home Phone (______) ____________________ Cell Phone (________) ___________________________

Work Phone (_____)___________________________ Marital Status ____

Ethnicity/Race: White Black/AA Hispanic/Latino _________ Asian _________ Other ____________ More than one ____________________

Email:____ (Used for special offers. To opt out, please check here: ☐)

Employer ____

Emergency Contact ____ Phone Number (________)_________________________________

I give my permission for ASD providers and staff to share and discuss my private health care information with the following:

Name: ____ Relationship: _______________________ Phone: _______________________

Name: ____ Relationship: _______________________ Phone: _______________________

Do we have permission to leave voice mail messages about your results and/or other private health information? Yes / No

Cell Number: Yes / No Home Number: Yes / No Work Number: Yes / No

How did you hear about our office? ____

RESPONSIBLE PARTY

Guarantor's Name ____ Phone Number (_______)___________________________

Address ____ City _______________________________________ State _______ Zip ___________
(If different from above)

Patient Relation to Guarantor ____ Guarantor Employer ____________________________________

Employer Address: City ____ State ___________ Zip __________________________

Guarantor SS# : ____ ____ ____ - ____ ____ - ____ ____ ____ ____ Guarantor Birth date: ______ - ________ - ___________

PRIMARY

Name of Insurance Company ____ Policy Holder _________________________________

ID Number ____ Group Number ____________________________

SECONDARY

Name of Insurance Company ____ Policy Holder _________________________________

ID Number ____ Group Number ____________________________________

I hereby authorize The Art & Science of Dermatology, P.C. to release medical information to any of my physicians or insurance companies that may be pertinent to my case and to any person indicated per above. I hereby authorize payment directly to The Art & Science of Dermatology, P.C. of benefits otherwise payable to me. I hereby authorize the release of medical records to third party insurers or other authorized persons to whom disclosure is necessary to establish or collect a fee for the service. I understand that I am financially responsible for charges not covered by this authorization. A photocopy of this authorization shall be valid as the original.

I certify that I have read and fully understand the above statement and consent fully and voluntarily to its contents.

Patient's signature (or responsible party) ____ Date ____________________________