

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: _____

Employer _____

Emergency Contact _____ Phone Number (_____) _____

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 _____