New Patient Registration

Medical Records Number _____ Today`s Date : _____

(Office use only)

PATIENT NAME: (This section refers to PATIENT ONLY)

Patient name : _____ _____ _____

First name Mid name Last name

Your birthday : __/__/____ Age:____ Sex : ☐ Male ☐ Female Social security# : ___-__-____

Address : _____ APT #: _____ City : _____ State : _____ Zip : _____

Email address : _____ Permission to send newsletter/information : ☐ Yes ☐ No

Telephone home #: (___) - ___ - ____ Telephone work #: (___) - ___ - ____ Ext: ____

Employer : _____ Occupation : _____

Spouse name : _____ Employer : _____

Telephone work #: (___) - ___ - ____ Ext: ____

How did you hear about us? _____ Whom may we thank for referring you? _____

Referring physician name : _____ Physician Telephone #: (___) - ___ - ____

Primary care physician (PCP) : _____ Physician Telephone #: (___) - ___ - ____

Relationship to responsible party : ☐ Self ☐ Spouse ☐ Son ☐ Daughter ☐ Other

RESPONSIBLE PARTY: (Person who should receive the bill)

Responsible party name : _____ Telephone home #: (___) - ___ - ____

Responsible party Birthday : __/__/____ Age:____ Social security# : ___-__-____

Employer name : _____ Telephone work #: (___) - ___ - ____ Ext: ____

Address : _____ APT #: _____ City : _____ State : _____ Zip : _____

INSURANCE: (Please complete thoroughly. We will need a copy of your insurance card.)

Primary insurance : _____ Telephone #: (___) - ___ - ____

Address : _____ APT #: _____ City : _____ State : _____ Zip : _____

Primary insured person : _____ ID/Policy # : _____ Suffix : _____ Group #: _____

Employer : _____ Co-Payment $: _____

Secondary insurance : _____ Telephone #: (___) - ___ - ____

Address : _____ APT #: _____ City : _____ State : _____ Zip : _____

Secondary insured person : _____ ID/Policy # : _____ Suffix : _____ Group #: _____

Employer : _____ Co-Payment $: _____

Auto Injury : ☐ Claim #:_____ Date of Accident : __/__/____

Work Comp : ☐ Claim #:_____ Date of Accident : __/__/____

Other Injury (Specify) : ☐ Claim #:_____ Date of Accident : __/__/____

NOTIFY IN EMERGENCY: (Not living with you)

Name : _____ Relationship : _____ Telephone #: (___) - ___ - ____

CONSENT FOR TEST RESULTS

I give AboutSkin Dermatology and DermSurgery, PC permission to leave all X-ray, lab results, test results, and other medical information and advice on: (check all that apply)

☐ Voice mail at work ☐ Answering machine at home ☐ Other _____ ☐ Do not leave message

☐ I hereby acknowledge that I have received a copy of AboutSkin Dermatology and DermSurgery, PC Notice of Privacy Practices. I authorize the release of any medical information and payment of medical benefits to the undersigned physician or supplier for services necessary to process a claim. I agree to be responsible for any deductible, co-insurance, co-pay, or any other balance not paid by my insurance.

Signature : _____ Relationship to patient : ☐ Self ☐ Parent ☐ Guardian Date : _____