ADVANCED DERMATOLOGY

PATIENT REGISTRATION INFORMATION

Name: _____What would you like to be called? _____
Last, First, MI

Home Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Date of Birth: _____Age: _____Sex: M F Social Security Number: _____

Email address:_____ **OK to Web Enable w/ Pt. Portal: Y N**

Preferred contact number (please circle): HOME CELL WORK

Employer's Name & Address: _____Occupation: _____
If student: _Full Time _Part Time
Name of School: _____
Marital Status: ____Minor ___Single ___Married ___Widowed ___ Divorced ___Separated

Name of Spouse (or Legal Guardians if Minor): _____

Patient's Medical Doctor (Internist/Family Practitioner/Pediatrician): _____
Address: _____ Phone: _____

Pharmacy name & phone number: _____

How did you hear about us? /Referred by? _____

Primary Medical Insurance _____S*econdary* Medical Insurance _____

PAYMENT INFORMATION
Office Policy: Payment is expected at the time of your visit for any deductibles, co-payments, unpaid Medicare or insurance balances and any cosmetic procedures or skin care products. We appreciate your cooperation in settling your account at each office visit. If your insurance plan is responsible for payment, please present your insurance card to our reception desk.

Do we have permission to leave medical information on your answering machine:

1. At home? Yes_____No_____
2. At your place of employment? Yes_____No_____
3. On your cell phone? Yes_____No____

Do we have permission to discuss your medical condition with any member of your household? Yes_____No_____
If yes, whom: _____ Relationship_____ Phone _____

Emergency Contact: _____ Relationship_____ Phone_____

_____ _____
Signature (Legal Guardian if Minor) Date

HIPAA FORM COPY ACKNOWLEDGEMENT (attached)
Signature below is only acknowledgement that you have received a copy of our Privacy Practices.

Print Name_____ Signature _____ Date _____

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