

The Art and Science of Dermatology

Patient Registration Form
Please always use black ink only

PATIENT INFORMATION

Referring Physician _____

Patient Name: Last _____ First _____ Middle _____

Address _____ City _____ State _____ ZIP _____

Sex: (Please Circle) Male / Female Title: (Please Circle) Dr. Mr. Mrs. Ms.

Social Security # _____ - _____ - _____ Email: _____

Birth date _____ - _____ - _____ Home Phone (_____) _____ Cell Phone (_____) _____

Work Phone (_____) _____ Marital Status _____

Employer/Address _____ City _____ State _____

Emergency Contact _____ Phone Number (_____) _____

Who may we thank for referring you to 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. 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 _____