ALLIED DERMATOLOGY AND SKIN SURGERY

PATIENT REGISTRATION FORM

PATIENT NAME:		
SSN:	OCCUPATION:	
DATE OF BIRTH:	AGE:	SEX: M F
ADDRESS:		
CITY:	STATE:	ZIP CODE:
HOME PHONE:	CELL PHONE:	WORK PHONE:
YOUR PREFERED CONTACT (CIRCLE ONE): HOME WORK CELL		
IS IT OK TO LEAVE A DETAILED MESSAGE?* YES_____ NO_____		
*MESSAGES WOULD INCLUDE LAB WORK, BIOPSY RESULTS, ETC.		
EMAIL ADDRESS:		

MARITAL STATUS: S M
*PRIMARY LANGUAGE: ENGLISH____ SPANISH____ OTHER____ DECLINE____
*RACE: CAUCASIAN____ AFRICAN AMERICAN ____ ASIAN____ DECLINE____
*ETHNICITY: NON-HISPANIC____ HISPANIC____ DECLINE____
*WE ARE REQUIRED TO COLLECT THIS DATA TO COMPLY WITH MEDICARE REQUIREMENTS FOR ELECTRONIC MEDICAL RECORDS

RESPONSIBLE PARTY (PRIMARY CARD HOLDER) INFORMATION		
NAME:		
ADDRESS:		
CITY:	STATE:	ZIP CODE:
SSN:	DATE OF BIRTH:	SEX: M F

EMERGENCY CONTACT		
NAME:	RELATIONSHIP:	PHONE:

PERSONS PERMITTED TO SPEAK WITH REGARDING MEDICAL INFORMATION		
NAME:	RELATIONSHIP:	PHONE:

OVER →

PATIENT REGISTRATION FORM

PATIENT NAME:

PHARMACY INFORMATION		
MAIL ORDER:		
LOCAL PHARMACY:		PHONE:
ADDRESS:		
CITY:	STATE:	ZIP CODE:

PRIMARY CARE DOCTOR:		
ADDRESS:		PHONE:
CITY:	STATE:	ZIP CODE:

REFERRING DOCTOR:		
ADDRESS:		PHONE:
CITY:	STATE:	ZIP CODE:

AUTHORIZATION FOR PAYMENT OF BENEFITS/RELEASE OF MEDICAL INFORMATION
I request that payments from my insurance company (companies) be made directly to ALLIED DERMATOLOGY AND SKIN SURGERY, LLC. I understand that I am responsible for any balances not covered by my insurance.
X SIGNATURE **DATE**
AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION
Signing below permits ALLIED DERMATOLOGY AND SKIN SURGERY, LLC to use and disclose health information about you for treatment, payment, and health care operations in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Copy available upon request)
X SIGNATURE **DATE**

***FOR OFFICE USE ONLY**

INITIAL BELOW TO VERIFY ALL INFORMATION IS CORRECT

_____2021 _____2022 _____2023 _____2024 _____2025