



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 PREFERRED 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:
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PERSONS PERMITTED TO SPEAK WITH REGARDING MEDICAL INFORMATION

NAME:	RELATIONSHIP:	PHONE:
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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.

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)

SIGNATURE

DATE

***FOR OFFICE USE ONLY**

INITIAL BELOW TO VERIFY ALL INFORMATION IS CORRECT

_____ 2022

_____ 2023

_____ 2024

_____ 2025

_____ 2026