

Consulting Dermatologic Specialists

Patient Registration Form

Private Pay Insurance Medicare Minor Child

****Please present your insurance card(s) and your photo ID to the receptionist. The receptionist will make a copy and return them to you.**

****PLEASE PRINT** **PLEASE PRINT** **PLEASE PRINT****

Patient Information

Social Security #: _____ Drivers License #: _____ (State) _____

Last Name: _____ First Name: _____ MI: _____ Jr. / Sr.(circle)

Date of Birth: _____ Sex: M F Married Single Divorced Widow

Address: _____ City: _____ State: _____ Zip: _____

Phone #'s: Home _____ Work _____ Cell _____

Employer Name: _____

May we contact you by email? yes no if yes: email address: _____

How were you referred to our office?

Internet (website): _____ Newspaper: (specify) _____

Magazine (specify) _____ Friend Other: _____

Physician Referral Information: (Please Complete if you have been referred by a physician)

Physician: _____ Number: _____

Insurance Information (In order to file claim correctly please **complete** this information)

Primary Insurance Coverage

Insurance Company Name: _____

Subscriber Name (Insured): _____

Subscriber Date of Birth: _____ Social Security Number: _____

Employer: _____ Relationship to patient: _____

Secondary Insurance Coverage

Insurance Company Name: _____

Subscriber Name (Insured): _____

Subscriber Date of Birth: _____ Social Security Number: _____

Employer: _____ Relationship to patient: _____

Emergency Contact Information

In the event of an emergency, whom should we contact? _____

Relationship: _____ Phone # () _____
NAME

