

# Consulting Dermatologic Specialists

## Patient Registration Form

Private Pay    Insurance    Medicare    Minor Child

**\*\*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

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

**(OVER)**

