PATIENT REGISTRATION FORM

Patient Name: _____ Date: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell: _____ Work: _____

SSN#: _____ Age: _____ Date of Birth: _____ Marital Status: _____ Gender: _____

Preferred Method of contact for Follow-Up Visits: ☐ Home Phone ☐ Cell Phone ☐ Other: _____

Preferred Language: _____ Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ☐ White/Caucasian ☐ African American ☐ Asian ☐ American Indian ☐ Pacific Islander ☐ Other

How did you hear about our office? _____ E-mail: _____

Occupation: _____ Employer: _____
(Parent's if patient is a minor) (Parent's if patient is a minor)

Referred by Dr.: _____ Phone: _____

Primary Care Dr.: _____ Phone: _____

Primary Insurance: _____ Relationship of patient to policyholder: _____

Insurance ID #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Address & Phone # of Policyholder if Different: _____

Secondary Insurance: _____ Relationship of patient to policyholder: _____

Insurance ID #: _____ Group #: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Address & Phone # of Policyholder if Different: _____

Third Insurance company information is not collected and not submitted for reimbursement. Patients are responsible for these balances.

Patient's or Authorized Signature

The information provided above is correct. I realize that I will be responsible in full for any service not covered by my insurance carrier(s). I realize that **I am responsible for any charges incurred due to incorrect information** I have provided. I authorize the release of any medical information necessary to process any claim and the payment of medical benefits to West County Dermatology.

I have received and had the opportunity to review a copy of West County Dermatology's Notice of Privacy Practices. I agree to receive marketing materials from this office for announcements or services that may benefit me.

Signed: _____ Relationship: _____ Date: _____

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