# PATIENT REGISTRATION FORM

Today's Date____/_____/_____

**Name** ______________________________________________
Last First MI

Date of Birth _____/_____/_____ Age_________ Sex_________ Marital Status_______________

SSN ________________________________

Mailing Address ______________________________________________
City State Zip Code

Home Phone ( ____ )______________ Work Phone ( ____ )______________ Cell Phone ( ____ )______________

Employer____________________/ Occupation______________________________

**PARENT OR RESPONSIBLE PARTY (if different from patient)**

**Name** ______________________________________________
Last First MI

Address ______________________________________________
City State Zip Code

Home Phone ( ____ )______________Work Phone ( ____ )______________Cell Phone ( ____ )______________

Date of Birth _____/_____/_____ Sex__________ SSN ______________________________

**INSURANCE INFORMATION (Please present insurance card at time of check in.)**

**Primary Insurance Name** ______________________

Insurance Address ______________________

Name of Policy Holder______________________

DOB____/____/____SSN of Policy Holder ____________

Insurance phone #______________________

Insured's ID#______________________

Group #______________________

Relationship of patient to Policy Holder____________

**Secondary Insurance Name** ______________________

Insurance Address ______________________

Name of Policy Holder______________________

DOB____/____/____SSN of Policy Holder ____________

Insurance phone #______________________

Insured's ID#______________________

Group #______________________

Relationship of patient to Policy Holder____________

In Case of emergency, person to contact other than spouse______________________________

Address ______________________________________Phone ( ____ )______________

Primary Care Physician ______________________ Physician Location ______________________

How may we contact you regarding follow-up, labs or biopsy results, etc.?

Send a message via e-mail? (This includes normal lab results) ❑ YES ❑ NO E-mail:______________________

What phone number do you prefer us to call? Home❑ Cell❑ Work❑

May we leave a message? Home❑ Cell❑ Work❑ (Please check all that apply)

Discuss your medical condition with any member of your household? ❑ YES ❑ NO

If yes, whom______________________ Relationship______________________

I hereby request the professional services of MOSKOWITZ DERMATOLOGY, M.D., P.L.L.C. and agree to financial responsibility as indicated in the paragraph below:

We only file insurance claims to plans in which we participate. If you are not covered by one of the insurance plans that we participate in, then payment is expected at the time of service. I authorize the release of medical information necessary to process claims and also authorize payment of medical benefits to the physician. If insurance does not pay, I will become financially responsible for payment in full.

**SIGNATURE OF PATIENT OR LEGAL GUARDIAN**______________________________**DATE**______________