

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 _____ **Secondary Insurance Name** _____

Insurance Address _____ Insurance Address _____

Name of Policy Holder _____ Name of Policy Holder _____

DOB ____/____/____ SSN of Policy Holder _____ DOB ____/____/____ SSN of Policy Holder _____

Insurance phone # _____ Insurance phone # _____

Insured's ID# _____ Insured's ID# _____

Group # _____ Group # _____

Relationship of patient to Policy Holder _____ Relationship of patient to Policy Holder _____

In Case of emergency, person to contact _____

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 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** _____

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