Patient Registration

_______________________________ M F ____/____/____ ______-______- ________

Patient's Name | **Sex** | **DOB** | **Social Security Number (required unless minor)**

____

Address | **City** | **State** | **Zip code**

EMAIL ADDRESS ____

☐ (____)____________________ ☐ (____)____________________ ☐ (____)____________________

Home Phone | **Work Phone** | **Cell Phone**

Place an X in the appropriate box above to specify the preferred daytime contact number.

____

Permanent address | **City** | **State** | **Zip code**

_______________ ____

Occupation | **Employer Name** | **Address** | **Phone**

Emergency contact/relationship: ________________________________ **Phone:** (______)__________________

Personal physician (PCP):

Name: ______________________________ **Phone #:** ______________________ **City/State:** ________________________

Were you referred to our office by your personal physician (PCP)? **Yes** **No** **Or other physician? (list below)**

Doctor's name?: ____ **Phone #:** ________________________________

Guarantor: *(Please complete if the patient is a minor)*

The person who is signing for treatment of the minor today must register as the guarantor.

________________________________ _____/_____/_____ _______-_______-___________

Name/Relationship | DOB | Social Security Number **(required)**

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Address (If different than patient's) | City, State, Zip code

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Is your visit today related to: Auto accident ☐ Worker's compensation ☐ Other accident ☐ None ☐

If yes, please notify the Patient Service Representative at the front desk to receive further instructions.

Primary Insurance Information

Insurance Company Name________________________________ Policy/ID #: ________________________________

Policyholder name/relationship: ____________________________ D.O.B.______/______/______ SS#________-________-________

Insured's employer name/address____ Phone: (_______)__________________

Secondary Insurance Information

Insurance Company Name________________________________ Policy/ID #: ________________________________

Policyholder name/relationship: ____________________________ D.O.B.______/______/______ SS#________-________-________

Insured's employer name/address____ Phone: (_______)__________________

Medicare patients: If you have **Medicare insurance**, are you or your spouse currently employed? Yes No
If yes, do you or your spouse have insurance through your employer? Yes No

Tricare patients: If you have **Tricare insurance**, is the policyholder active duty? Yes No

I request that payment of insurer benefits be made on my behalf to **Innovative Dermatology (ID)** for services furnished to me. Furthermore, I have authorized **ID** to release to my insurance carrier(s) any and all information needed to determine the benefits payable for related services. Although the providers of **ID** may or may not participate with my insurance carrier(s), I understand that I am financially responsible for any co-payments, deductibles or unpaid balances.

____ ______________________

Signature of patient/guarantor | Date