

# Patient Registration Form



Arizona  
Dermatology  
Group

## How did you hear about our practice?

(Information provided is strictly for marketing purposes and appreciation letters.)

- Established patient with our practice  
 Yellow Pages  
 Doctor's Office—Please List: \_\_\_\_\_  
 Newspaper—Please List Name of Newspaper: \_\_\_\_\_  
 Friend/Relative—Please List: \_\_\_\_\_  
 Other—Please List: \_\_\_\_\_

## PATIENT INFORMATION

Legal Name: \_\_\_\_\_  Jr.  Sr.

First

Middle

Last

Sex:  Male  Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
Street City State Zip

Phone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_

## MARITAL INFORMATION Marital Status: Single Married Divorced Widowed

Spouse's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_

## MINOR INFORMATION (17 YEARS AND YOUNGER)

Legal Guardian/Parent Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Legal Guardian/Parent Social Security #: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

## INSURANCE INFORMATION

Do you have insurance?  Yes  No If yes, please completely fill out below to ensure payment:

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Relationship to Policy Holder:  Self  Spouse  Parent  Other

If **NOT** self, please complete with POLICY HOLDER information:

Policy Holder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security #: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Employer of Policy Holder: \_\_\_\_\_

Address if different from patient: \_\_\_\_\_  
Street City, State Zip

May we leave personal medical information on your answering machine at home?  Yes  No

May we call you at your place of employment or leave a message with your employer?  Yes  No

Do you give us permission to discuss your medical information with family members?  Yes  No

If Yes, please provide names: \_\_\_\_\_

In case of an emergency whom should we notify? Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Who is your primary care physician (PCP): \_\_\_\_\_ PCP's Phone Number: \_\_\_\_\_

BY SIGNING BELOW YOU ACKNOWLEDGE THE ABOVE INFORMATION PROVIDED IS TRUE AND CORRECT TO THE BEST OF YOUR KNOWLEDGE. YOU ALSO ACKNOWLEDGE YOU HAVE OBTAINED, UNDERSTAND, AND AGREE TO ABIDE BY THE GUIDELINES CONTAINED IN THE RELEASE INFORMATION AND PATIENT FINANCIAL POLICY.

\_\_\_\_\_  
SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE/PARENT

\_\_\_\_\_  
DATE

Last updated 2/2/2010