Welcome to Affiliated Dermatologists, S.C. Patient Registration

Date: _____ Referring Physician (if any): _____ Acct #: _____ _____
Provider

Personal Physician: _____

Name: ( ) MR ( ) MRS ( ) Miss _____
( ) MS ( ) M.D. ( ) DDS ( ) PhD ( ) REV ( ) SR Last First Middle

Address: _____
Street City State Zip

Age: _____ Birthdate: _____ Social Security #: _____

Patient's Employer: _____ Work Phone: _____

Home Phone: _____ Cell Phone: _____

What is the **PRIMARY** phone number for reminder calls and messages? (circle one) H / W / C
H=Home W=Work C=Cell

Emergency Contact Information:

In case of Emergency, who should be notified? _____ Phone: _____

Relationship to patient: _____

Primary Insurance Information	**Secondary Insurance Information**
Insurance Company Name: _____	Insurance Company Name: _____
Policyholder's Name: _____	Policyholder's Name: _____
Policyholder's Birthdate: _____	Policyholder's Birthdate: _____
Policyholder's Social Security #: _____	Policyholder's Social Security #: _____
Policyholder's Relationship to Patient: _____	Policyholder's Relationship to Patient: _____

Parent, Spouse, or Responsible Party (*if different from patient*)

Name: _____

Address: _____
Street City, State, Zip

Home Phone: ( ) _____ Work Phone: ( ) _____

Signature of Patient/Legal Rep: **X**_____ Date: _____

Are you interested in receiving promotional information about Aesthetic services at our Skin and Laser Center?

Email: _____