Associates in Dermatology, Inc.

Patient Registration
Please PRINT All Information

PATIENT INFORMATION DATE

PATIENT'S NAME (LAST, FIRST, MI)			DATE OF BIRTH
STREET ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	
PREFERRED PHONE (CHECK ONE) ☐ Home ☐ Work ☐ Cell		SOCIAL SECURITY #	
EMAIL ADDRESS:			
GENDER AT BIRTH ☐ Male ☐ Female	GENDER IDENTITY ☐ Male ☐ Female ☐ Other _____	MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Divorced	
PREFERRED LANGUAGE ☐ English ☐ Spanish ☐ Other	RACE ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other	ETHNICITY ☐ Non-Hispanic ☐ Hispanic ☐ Other	
REFERRING PHYSICIAN	PCP		

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY	ID#
SECONDARY INSURANCE COMPANY	ID#
TERTIARY INSURNACE COMPANY	ID#

DO YOU HAVE ANY INSURANCE COVERAGE AFFILIATED WITH THE MILITARY? (TRICARE, VA OPTUM) ☐ Yes ☐ No

FOR MINORS ONLY		
GUARANTOR/RESPONSIBLE PARTY	RELATIONSHIP TO PATIENT	
CONTACT#	DATE OF BIRTH	SOCIAL SECURITY #

ADDITIONAL CONTACT INFORMATION (SOMEONE NOT LIVING IN THE SAME RESIDENCE)

NAME	RELATIONSHIP TO PATIENT		
ADDRESS	CITY	STATE	ZIP
CONTACT#			

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Friend/Family ☐ PCP ☐ Internet ☐ Advertisement ☐ Insurance Company ☐ Local Event