

Patient registration form

Instructions: Please complete all sections of this form in blue or black ink or by typing into the interactive fields if viewing online

Patient information

Name (last, first, middle initial):

Mailing address:

Street (if different from mailing address):

City: State: Zip

Primary phone: Mobile phone:

Email Address:

Date of birth: / /

Sex assigned at birth (choose one):

Female

Male

Prefer not to say

Gender (optional):

Woman

Man

Nonbinary

Prefer to self describe:

Ethnicity (choose all that apply):

American Indian or Alaska Native

Asian

Black or African American

Hispanic or Latino

Native Hawaiian or Pacific Islander

White

Other:

Prefer not to say

Preferred language:

English

Spanish

Other:

Emergency contact

Name: Relationship to patient:
Primary phone: Mobile phone:

Responsible party

Only complete this section if someone other than the patient is legally or financially responsible

Name (last, first, middle initial):

Mailing address:

Street (if different from mailing address):

City: State: Zip:

Primary phone: Mobile phone:

Email address:

Insurance

Insurance or self pay:

I have insurance

I am self pay

Primary insurance company:

ID #: Group #

Subscriber name:

DOB: / / Relationship to patient:

Secondary insurance company:

ID #: Group #:

SSN: (if Medicare is secondary insurance)

If Medicare is your secondary insurance we may need your SSN for coordination of benefits.

Subscriber name:

DOB: / / Relationship to patient:

Providers & pharmacy

Name of preferred pharmacy & location:

Primary care physician: Referring doctor:

Financial responsibility and assignment of benefits

I authorize billing of my insurance and assign benefits directly to the practice. I agree to pay amounts not covered by insurance, including copays at time of service. Fees for missed or late-canceled appointments and other charges are per our posted policy available at our front desk and on our website. If a biopsy or specimen is taken, I consent to it being sent to an outside laboratory, which may be billed separately.

How we contact you

We may contact you about appointments and scheduling. Choose your preferences; you can change these at any time.

Text messages: Yes No

(Note: text messages may not be secure.)

Preferred phone for calls/voicemail: Primary number Mobile number

OK to leave a detailed voicemail? Yes No

People we may talk to about your care

I authorize the practice to share information about my care with the individuals listed below:

Name:

Relationship to patient:

Phone:

Name:

Relationship to patient:

Phone:

Clinical photography for your medical record

I consent to clinical photos being taken to treat and document skin conditions. These images will become part of my secure, HIPAA-protected medical record.

HIPAA notice acknowledgment

I received or was offered the practice's Notice of privacy practices. It is available at the front desk and on our website.

Signature

By signing below, I confirm that the information I provided on the registration form is true and complete to the best of my knowledge. I consent to receive evaluation and treatment as recommended by my clinician, and I understand I may ask questions and revoke this consent at any time.

I acknowledge and agree to the consents and acknowledgments listed above.

Patient or responsible party signature:

Date: / /

(if signed by responsible party, please print name and relationship)