DOCS
DERMATOLOGY GROUP

REGISTRATION FORM

Complete for all new patients; update every two years and when a minor turns 18.

Name: _____ Date of Birth:_____/_____/_____
Last First MI

Birth Sex: M / F Preferred Gender: ☐ M ☐ F ☐ NB

Mobile Phone#: _____ Other (work/home)#: _____

Email: _____

Mailing Address: _____
City: _____ State: _____ Zip Code: _____

Preferred Pharmacy: _____
City or Zip Code: _____ Phone #: _____

Primary Care Provider: _____

Can we leave you a detailed message? ☐ Yes ☐ No
Do you authorize medical information regarding your care, test results, appointments, billing information, etc., to be shared with someone other than yourself? ☐ Yes (list below) ☐ No

Name: _____ Relation: _____ Phone#: _____
Name: _____ Relation: _____ Phone#: _____
Name: _____ Relation: _____ Phone#: _____

Emergency Contact: _____ Phone#: _____
Last First

Is the insurance Policy Under You (e.g. Subscriber)? ☐ Yes ☐ No (If not, please give subscriber information below)

Subscribe Name: _____ Subscriber Date of Birth: _____/_____/_____
Relation to Patient: Parent Spouse Other: _____

Address the same as above? ☐ Yes ☐ No (If not, please list below)
Address: _____-
City: _____ State: _____ Zip Code: _____

Do you have Secondary Insurance Plan: ☐ Yes ☐ No
Is the Secondary Insurance Policy Under You (e.g. Subscriber)? Yes No (If not, please give subscriber information below)

Subscribe Name: _____ Subscriber Date of Birth: _____/_____/_____
Relation to Patient: ☐ Parent ☐ Spouse ☐ Other: _____

Is the Patient Under 18? ☐ Yes (If yes, please complete below financial guarantor information) ☐ No

Guarantor Name: _____ Date of Birth: _____/_____/_____
Guarantor Address: _____
City: _____ State: _____ Zip Code: _____
Relation to Patient: ☐ Parent ☐ Spouse ☐ Other: _____

Signature: _____ Date: _____