DERMATOLOGY INSTITUTE & LASER CENTER

Patient Registration

Patient Information

Date ____/_____/_____

First Name _____ Last Name _____

Address _____

Address cont'd _____

City _____ State _____ Zip _____

Home # _____ Cell # _____ Work # _____

Date of Birth ____/____/____ Age _____ Sex _____ Marital Status _____

Occupation _____

SSN _____-_____-_____ Email _____

As part of the Federal Government's "Meaningful Use" initiative for electronic health records, we are required to request the following information. You may choose not to report some or all of this information.

Race _____ Ethnicity _____ Primary Language _____

Parent of Responsible Party Information (if different than patient)

First Name _____ Last Name _____

Address _____

Address cont'd _____

City _____ State _____ Zip _____

Home # _____ Cell # _____ Work # _____

Date of Birth ____/____/____ Sex _____ Relationship to Patient _____

SSN _____-_____-_____ Email _____

Emergency Contact Information

Person to notify in case of emergency _____

Relationship to Patient _____

Home # _____ Cell # _____ Work # _____

Primary Care Information

Primary Care Physician Name _____ Phone # _____

Pharmacy Name _____ Phone # _____

DERMATOLOGY INSTITUTE & LASER CENTER

Patient Registration (continued)

Insurance Information

Please present insurance card(s) and photo ID at time of check in

PRIMARY

Insurance Name _____

Policy ID #_____ Group # _____

Name of Policy Holder (Insured) _____

Date of Birth ____/____/____ SSN _____-_____-_____

Relationship to Patient _____

Policy Holder's Employer _____ Phone _____

SECONDARY

Insurance Name _____

Policy ID #_____ Group # _____

Name of Policy Holder (Insured) _____

Date of Birth ____/____/____ SSN _____-_____-_____

Relationship to Patient _____

Policy Holder's Employer _____ Phone _____

Verification

Please initial and sign below

_____I hereby verify the information on this registration form is correct and acknowledge it is my responsibility to keep you informed of any and all changes, including address and insurance information.

_____I also consent to necessary treatment, including drugs, medicine, performance of operations and conduct studies that may be used by Dr. Ros, her nurse, or staff.

_____I am aware that I may obtain a copy of the Notice of Privacy Practices for Dermatology Institute & Laser Center by request at the office or online at www.drros.com.

Signature _____ Date _____