ADVANCED DERMATOLOGY
of the Midlands

Today's Date:

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient's Legal Last Name:	Legal First Name:	Middle Name:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Preferred Name/Nickname?	Preferred Phone No: ( )	Birth Date: / /	Age:	Sex: ❑ M ❑ F

Street address:	City:	State:

Zip Code:	Social Security No:	Email Address:	Race: Ethnicity:

RESPONSIBLE PARTY INFORMATION

Person responsible for bill:	Address (if different):	Preferred contact phone no.: ( )
Relationship to Patient:	Social Security no:	Birth Date: / /

INSURANCE INFORMATION

Name of primary insurance:	Name of subscriber (Person who carries Insurance):	Patient's relationship to subscriber:

Subscriber's employer	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Name of secondary insurance:	Name of Subscriber (Person who carries Insurance):	Patient's relationship to subscriber:

Secondary Insurance Subscriber's Employer:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

AUTHORIZATION/CONSENT

I hereby authorize Advanced Dermatology of the Midlands Clinic Staff to Release/Share my protected health information with the following people involved in my care: (Name MUST be listed in order for staff to discuss your care with them)

Name: *Relationship to Patient:* *Phone Number:*

Name: *Relationship to Patient:* *Phone Number:*

Please contact me as follows:
Home/Cell: ( ) ________ - ___________
☐ Leave message- appointment and date ☐ Leave message- lab/test results, prescription changes

Work phone: ( ) ________ - ___________
☐ Leave message- appointment and date ☐ Leave message- lab/test results, prescription changes

Primary Care Physician: ____ Phone Number: ________________________________

If you have authorized us to leave a message, please indicate specifics below:
☐ Voice mail/answering machine only ☐ Whoever answers the phone

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Advanced Dermatology of the Midlands or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*