

Welcome To DERMATOLOGY OFFICE, P.C.

Insurance Cards Copied

PATIENT REGISTRATION INFORMATION

Please PRINT and complete ALL sections below! If unable to complete, one of our staff members will assist you.

PERSONAL INFORMATION

Today's Date: _____

Marital Status: Single Married Divorced Widowed

Sex: Male Female

Name: _____
Last Name First Name Middle Initial Maiden Name

Street Address: _____ (Apt. # _____)

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone/Pager: (_____) _____ Email: _____

Date of Birth: _____ / _____ / _____ Social Security #: _____
Month Date Year

Pharmacy of Choice & Phone: _____

Employment Status: Student Employed Retired Disabled

Employer Name (if applicable): _____

Is your condition a result of a work injury? Yes No An automobile accident? Yes No

If yes, date of Injury: _____

If job related, person authorizing care _____

Phone: (_____) _____ Case # _____

Spouse's Name: _____ Spouse's Social Security #: _____

Spouse's Employer: _____ Employer's Phone #: (_____) _____

Address: _____

Do you wish correspondence to be confidential? Yes No May we contact you at work? Yes No

Reason for Visit: _____

REFERRAL INFORMATION

How did you hear of us? _____ Friend Doctor Insurance Co. Other

Referring Doctor: _____ Phone: (_____) _____

Primary Care Doctor (if different from referring): _____ Phone: (_____) _____

EMERGENCY CONTACT

Name of person not living with you: _____ Relationship: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE INFORMATION*Please present all insurance cards/documentation at each visit.*

Primary Insurance: _____ Co-Payment: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Policyholder's Name: _____ Date of Birth: ____/____/____

Relationship to Insured: _____

Insurance ID Number: _____ Group #: _____

Effective Date: ____/____/____

Secondary Insurance: _____ Co-Payment: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Policyholder's Name: _____ Date of Birth: ____/____/____

Relationship to Insured: _____

Insurance ID Number: _____ Group #: _____

Effective Date: ____/____/____

RESPONSIBLE PARTY INFORMATION*Complete if different from patient.*

Policyholder Name: _____ Date of Birth: ____/____/____

Relationship to Insured: _____

Responsible Party's Home Phone: (____) _____ Work Phone: (____) _____

Social Security #: _____ - _____ - _____

Address: _____ City/State/Zip: _____

METHOD OF PAYMENT FOR TODAY'S VISIT CASH CHECK VISA/MC**Assignment of Benefits • Financial Agreement**

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Lance Yeoman, D.O. and any assisting physicians for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and any reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits or coordination of care.

I further agree that a photocopy of this agreement shall be as valid as the original.

Patient or Responsible Party Signature: _____ Date: _____