

Patient Registration Form

Date: _____

Name: _____ Sex: M F Jr. Sr.
Last First Middle

Email: _____ Title: Mr. Dr. Mrs.
Ms. Miss

Marital Status: Married / Single / Divorced / Widowed / Separated / Domestic Partner

Address: _____
Street # Street Name Apt #
City State Zip

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

Home Phone: () _____ Work Phone: () _____ Cell #: () _____

Employer: _____
Name Address Phone Position

If Student: Full Time Part Time Name of School: _____

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance Name _____ Secondary Insurance Name _____

Member ID# _____ Member ID# _____

Name of Subscriber _____ Name of Subscriber _____

Sex: M ___ F ___ / S.S. # _____ Sex: M ___ F ___ / S.S. # _____

D.O.B. _____ D.O.B. _____

Employer Name _____ Employer Name _____

Relationship of the patient to the Subscriber _____ Relationship of the patient to the Insured _____

Other family members that are patients _____

In case of Emergency, who should be notified? _____ Phone () _____

Referred by _____ Phone () _____

Primary Care Physician _____ Phone () _____

I understand that I am financially responsible for all charges for services rendered and that a finance charge of 1% will accrue on any unpaid balance on my account older than 30 days. I authorize the release of medical information to my primary care or referring physician, to consultants, if needed and as necessary to process insurance claims, insurance applications and prescriptions. I authorize payment of medical benefits to Princeton Dermatology Associates.

Patient or Responsible Party Signature _____ Date ____ / ____ / ____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name _____
Last First M.I.

Address _____
City State Zip