Patient Registration Form

Date:________________

Name: ____ Sex at Birth: ☐ M ☐ F
Last First Middle
Gender ______________________________

Email: ____ Gender Pronouns ______________________

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

Address: ____
Street # Street Name Apt #

____
City State Zip

Preferred Language: _______________________ Race: ☐ White ☐ Black ☐ Latino ☐ Asian ☐ Other

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% may 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