Medical Dermatology Specialists, Inc.

PATIENT REGISTRATION FORM

5730 Glenridge Drive, Suite T-100, Atlanta, GA 30328

Patient Information:

Patient Name: _____ Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ **Sex:** M / F (**Circle one)** Married/Single/Divorced/Widow

Spouse Name: _____

Address: _____

Race: _____ Religion: _____ Primary Language: _____

Home Phone: (____) _____-_____ Work Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Primary Phone: _____**E-mail Address**: _____

Would you be interested in having communications sent to you via your e-mail address? (Examples: appointment Reminders, administrative updates and health bulletins) Yes **?** No?

Other Information:

Primary Care Physician: _____

Who referred you? _____

Preferred Pharmacy:

Pharmacy Name: _____ Address: _____

Pharmacy Phone: (____) _____ Pharmacy Fax: (____) _____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: _____ - _____ - _____

Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent Date of Birth: _____/_____/_____

Address: _____ Phone Number: _____

Emergency Contact:

Name: _____ Address: _____

Home Phone: (__) _____ - _____ Work Phone: (___) _____-_____ Relationship: _____

INSURANCE INFORMATION

Insurance Company: _____ Policy Holder: _____

Address: _____ Group Number: _____

Policy Holder ID#:_____ Policy Holder's DOB: ____/_____/_____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Medical Dermatologist Specialists. I acknowledge that I am financially responsible for payment whether or not covered by insurance. **(If under 18, parent or legal guardian must sign).**

Signature: _____ Date: _____