PATIENT INFORMATION

Last Name: ______________________________ First Name: ___________________________ M.I.____
Street Address/Apt#: ____
City: ____ State: _____________ Zip Code: ______________
Home Phone #: _____________________________
Work Phone #: _____________________________
Cell Phone #: _____________________________
Date of Birth: _______________________________ Sex: ( ) Male ( ) Female
Social Security #: ___________________________ Marital Status: ( ) Single ( ) Married ( ) Other
Employer: ___________________________________ Occupation: ___________________________
Driver License #: _____________________ REFERRING PHYSICIAN: _______________________
Emergency Contact: ___________________________ Emergency Tel. #: _______________________

INSURANCE INFORMATION

Primary Insurance Co.: __________________________ Insured's Name: _________________________
Insured's Date of Birth: _______________________ Relationship of Patient to Insured: ____________

Secondary Insurance Co.: _________________________ Insured's Name: _________________________
Insured's Date of Birth: _______________________ Relationship of Patient to Insured: ____________

Responsible Party: (to be completed ONLY if party is not the patient or not listed as the insured)
Last Name: ___________________________ First Name: __________________________ M.I.____
Street Address/Apt#: ____
City: ________________________________ State: _______________ Zip Code: ___________
Home #: ______________________________ Cell #: _______________________________
Date of Birth: ____________________________ Relationship to Patient: __________________________

***IF YOU ARE A NEW PATIENT, HOW DID YOU HEAR ABOUT US?** ____________________

Reason for visit: ____

What medications does the patient currently take? ____________________________________
____
____

Does the patient have any drug allergies? _____________ (if "YES", please list) ____________________
____

PAYMENT POLICY/AUTHORIZATION OF PAYMENT:

All professional services rendered are charged to the patient. The patient is responsible for payment regardless of insurance coverage. **Full payment** is expected at time of each office visit unless satisfactory arrangements have been made in advance. Billing information will be provided to expedite patient's reimbursement from private carrier. All co-payments, coinsurances, and deductibles are due and payable at the time services are rendered.

I hereby authorize the provider of services to release medical information concerning my examination and/or treatment for insurance purposes and to receive direct payment for medical benefits payable to TheSkinMD.com for services rendered.

I, the undersigned, have completed this registration form to the best of my knowledge. Also, I have read and fully understand the payment policy and authorization of payment outlined above.

Signature:____ **Date:**________________________
Printed Name:____