

 **REGISTRATION FORM**

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| --- | --- | --- | --- |
| **First Name**  | **M.I.** | **Last Name** | **Date** |
| **Spouse's Name** |  | **Parent / Guardian Full Name (If Patient is a Minor)** |
| **Patient Home Address** |   **City State Zip** |
| **Home Phone** | **Work Phone** | **Cell Phone** |
| **Patient E‐mail Address** |  | **Employer** |
| **Patient Occupation** |  | **Date of Birth** | **Age** | **Social Security Number** |
| **Pharmacy Phone Number** |  | **Referred By** |
| **Medical Illness** |  |
| **Medications** |  |
| **Allergies**  |  |
| **Previous Skin Diseases** |
| **Party Responsible for Payment** | **Health Insurance Carrier** |
| **ID#** |

**Subscriber Insurance Information (If other than patient)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Date of Birth** |  |  |
| **Address** |  **City**  | **State**  | **Zip** |
| **Social Security Number** | **Employer** |  |  |
| **Subscriber Phone Number** | **Relationship to Patient** |  |  |

**Emergency Contact Information**

|  |  |
| --- | --- |
| **Name** | **Phone** |

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| **Cancellation Policy: We request a minimum 24-hour notice for all appointment cancellations. A fee will be assessed for missed appointments if no notice is given.** |  |
| **Patient’s Signature:** |