

**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)**

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| --- | --- | --- | --- |
| **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:** | |