Town Square Dermatology Patient Registration Form

Today's Date:_____

Name: _____ Sex: ☐M ☐F
First *Middle* *Last*

Prefer to be called:_____ Date of Birth:_____/_____/_____
Nickname *Month* *Day* *Year*

Patient's Address:_____
Street # *Street Name* *Apt #*

_____
City *State* *Zip*

Home Phone: _____ Cell Phone: _____
Area Code *Area Code*

Which phone would you prefer us to call? Home ☐ Cell ☐

Billing Information (if different from patient)

Name: _____ Sex: ☐M ☐F
First *Middle* *Last*

Address: _____
Street # *Street Name* *Apt #*

_____
City *State* *Zip*

Home Phone: _____ Cell Phone: _____
Area Code *Area Code*

Insurance Information (Please present insurance card at time of check-in)

Primary Insurance
Name of Policy Holder:_____ Date of Birth:_____ / _____ / _____
First *Middle* *Last* *Month* *Day* *Year*

Secondary Insurance
Name of Policy Holder:_____ Date of Birth:_____ / _____ / _____
First *Middle* *Last* *Month* *Day* *Year*

Who referred you?_____ Pharmacy of Choice:_____
Do we have your permission to:
Leave a message on your answering machine at home? Yes ☐ No ☐
Discuss your medical condition with any member of your household? Yes ☐ No ☐

If yes, whom?_____ Relationship_____

_____ _____
Signature of Patient or Responsible Party *Date*

-Over-

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I am aware of the Provider's Notice of Privacy Practices posted at Town Square Dermatology. The Notice of Privacy Practices describes how identifiable health information may be used and disclosed and states your rights with respect to your medical information.

I understand that Town Square Dermatology has the right to revise these information practices and to amend the Notice of Privacy Practices. I understand that in the event that the notice is revised, the revised notice will be posted at Town Square Dermatology. At any time, upon request, I may obtain a copy of the Privacy Practices Policy.

Printed Patient Name

Signature of Patient/Guardian/Representative

Date signed