Town Square Dermatology Patient Registration Form

PATIENT INFORMATION

Full legal name (First, Middle, Last, suffix) _____ Nickname _____ Sex: ☐ Male ☐ Female

Date of birth _____ Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Life partner

Complete mailing address: _____
(Street, city, state, zip code, county)

Home phone number: _____ Cell phone number: _____ Work number: _____

Email: _____

Employment status: ☐ Full-time ☐ Part-time ☐ Active duty ☐ Self-employed ☐ Not employed ☐ Retirement date: _____

Employer name: _____ Employer phone number: _____

Employer complete address: _____
(Street, city, state, zip code)

SPOUSE OR GUARANTOR INFORMATION (Responsible party) ☐ Same as patient

Full legal name (First, Middle, Last, suffix) _____ Date of birth _____

Relation to patient: ☐ Self ☐ Spouse ☐ Mother ☐ Father ☐ Legal guardian ☐ Other: _____ Sex: ☐ Male ☐ Female

Home phone number: _____ Cell phone number: _____ Work number: _____

Complete mailing address - if different from patient: _____
(Street, city, state, zip code, county)

Employment status: ☐ Full-time ☐ Part-time ☐ Active duty ☐ Self-employed ☐ Not employed ☐ Retirement date: _____

Employer name: _____ Employer phone number: _____

Employer complete address: _____
(Street, city, state, zip code)

CONTACT INFORMATION

Home Phone: _____ Cell Phone: _____

Preferred Contact Method: ☐ Home Phone ☐ Cell Phone

Do we have your permission to…

Leave a message on your: ☐ Home Phone ☐ Cell Phone

Discuss your medical condition with any member of your household? ☐ Yes ☐ No

If yes, whom? _____ Relationship _____

Pharmacy of Choice: _____

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.

By signing below I affirm that the above information is correct. If any changes should occur I will contact Town Square Dermatology to update my file.

_____ _____
Signature of Patient/Guardian/Representative *Date Signed*