

Patient Registration Form

Please fill out this form and bring it with you to the SkinPros office.



Name _____ Today's date _____
LAST FIRST M.I.

Mailing Address _____ City _____ State _____ Zip _____
NUMBER, STREET, APARTMENT NUMBER

Age _____ Primary Language _____ Race _____ DECLINE TO ANSWER

Email _____ Ethnicity: HISPANIC OR LATINO NOT HISPANIC OR LATINO DECLINE TO ANSWER

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

Date of Birth ____ / ____ / ____ SS # _____ Marital Status _____ Gender _____

Employer _____ RETIRED FULL-TIME STUDENT PART-TIME STUDENT

Spouse's Name _____ Spouse's Employer _____ Work Phone (____) _____

Person to notify in case of emergency _____ Phone _____
(PLEASE LIST A PERSON NOT LIVING IN YOUR HOME)

Referring Doctor _____

Primary Doctor _____

Pharmacy Name/Address _____

May we leave a message on your home answering machine? Y N

May we leave a message for you at work to call us? Y N

May we discuss your medical condition with another person? Y N

If yes, whom? _____ Relationship _____

How did you hear about our practice? _____

Insurance Provider Name _____ Policy # _____ Group # _____

Policy Holder (if different from patient or responsible party) _____

Policy Holder's Date of Birth ____ / ____ / ____ SS # _____

Employer of Policy Holder _____ Work Phone (____) _____

Patient's Relationship to Policy Holder _____

If patient is a minor, please enter responsible party information. NOTE: We do not bill absent parents, the adult presenting the minor for care is the responsible party.

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