

# Town Square Dermatology Patient Registration Form

## Patient Information – 2011/2012

SSN#: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Sex  M  F  
*First Middle Last*

Prefer to be called: \_\_\_\_\_ Title:  Mr.  Mrs.  Ms.  Miss  Dr.

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ Employer: \_\_\_\_\_  
*Month Day Year*

Address: \_\_\_\_\_  
*Street # Street Name Apt #*

\_\_\_\_\_ *City State Zip*

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
*Area code Area Code Area Code*

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

## Parent or Responsible Party (if different from patient)

Name: \_\_\_\_\_ Sex  M  F  
*First Middle Last*

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ SSN# \_\_\_\_\_  
*Area code Area Code*

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

### Primary Insurance

Ins. Name \_\_\_\_\_  
Ins. Address \_\_\_\_\_  
Name of Insured \_\_\_\_\_  
Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Insured's ID# \_\_\_\_\_  
Group# \_\_\_\_\_  
Employer Name \_\_\_\_\_  
Relationship of patient to insured \_\_\_\_\_

### Secondary Insurance

Ins. Name \_\_\_\_\_  
Ins. Address \_\_\_\_\_  
Name of Insured \_\_\_\_\_  
Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Insured's ID# \_\_\_\_\_  
Group# \_\_\_\_\_  
Employer Name \_\_\_\_\_  
Relationship of patient to insured \_\_\_\_\_

Who referred you? \_\_\_\_\_ Pharmacy of Choice: \_\_\_\_\_

Do we have your permission to:

	Yes	No
Leave a message on your answering machine at home?	<input type="checkbox"/>	<input type="checkbox"/>
Leave a message at your place of employment?	<input type="checkbox"/>	<input type="checkbox"/>
Discuss your medical condition with any member of your household?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, whom? \_\_\_\_\_ Relationship \_\_\_\_\_

× \_\_\_\_\_  
*Signature of Patient or Responsible Party*

\_\_\_\_\_ *Date*

## 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.

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Printed Patient Name

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Signature of Patient/Guardian/Representative

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Date signed