



**Island Dermatology**

**PATIENT REGISTRATION FORM**

<b>PATIENT INFORMATION</b>		
First Name:	Last Name:	Middle Initial:
Address:		
City:	State:	Zip:
Home Phone (    )	Cell Phone (    ) Phone: Cell    Home	Preferred
<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	Social Security #:
Email Address: @		
Referred to clinic by:	Dr.	Friend/Family:
Primary Care Provider:		
Parent/Guardian Name: (If applicable)	Date of Birth:	
Insurance Subscriber Name:	Date of Birth:	
<b>***May we leave a <i>detailed</i> message on voicemail, answering machine, or with another person regarding an appointment, lab/biopsy results, or other medical concerns?   YES   NO</b>		
<b>PRIMARY INSURANCE INFORMATION</b> (Please give your insurance cards to our receptionist)		
Insurance Carrier:	ID#:	Group #:
Subscriber Address: (If different from patient)		
Phone Number:		
<b>SECONDARY INSURANCE INFORMATION</b>		

Insurance Carrier:	ID #	Group #:
Subscriber Name:		
Subscriber Address: (If different from patient)		
Phone Number:		
<b>IN CASE OF EMERGENCY</b>		
Name of nearest friend or relative (not living with you):		
Relationship to patient:	Phone Number: (    )	
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Island Dermatology or insurance company to release any information required to process my claims.		
<b>Patient/Parent or Guardian signature</b>	<b>Date</b>	