Updegraff Clinic for Allergy and Dermatology

PATIENT REGISTRATION FORM

(Please Print)

Today's Date: _____

PATIENT INFORMATION

Patient's Last Name: _____ First: _____ Middle: _____

☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. Marital Status (circle one) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Primary language spoken: _____ Ethnicity: _____ Race: _____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F

Street Address: _____ City: _____ State: _____ Zip Code: _____

Social Security No.: _____ Home Phone No.: _____

Email Address: _____

Occupation: _____ Employer: _____ Employer Phone No.: _____

Referred to clinic by (please check one) ☐ Hospital ☐ Dr. ☐ Insurance Plan ☐ Family/Friend ☐ Close to home/work

☐ Attended Lecture ☐ Yellow Pages ☐ Advertisement ☐ Other, please specify: _____

Other family members seen here: _____

RESPONSIBLE PARTY & INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

PRIMARY INSURANCE:

Name of Primary Insurance Company: _____

Subscriber's Name: _____ Date of Birth: _____

Address (if different): _____ Home Phone No.: _____

Employer: _____ Employer Address: _____

Employer Phone No.: _____ Subscriber's SS#: _____

Policy #: _____ Group #: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

SECONDARY INSURANCE:

Name of Secondary Insurance Company: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber's SS#: _____ Policy #: _____ Group #: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

In the event that we call your home to remind you of an appointment, or to provide you with your test results, do we have permission to:

Leave a message on your answering machine at home about your medical condition? ☐ Yes ☐ No

Leave a message at your place of employment? ☐ Yes ☐ No If yes, phone number _____

Discuss your medical condition with any members of your household? ☐ Yes ☐ No If yes, with whom: _____

In connection with medical services received, I consent and authorize Updegraff Clinic for Allergy and Dermatology to make and store photograph(s) for the purpose of documenting the location and appearance of a lesion(s) on my body. The photographs will not be used for any other purpose. I also consent for any treatment deemed necessary by the provider to include a verbal consent.

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 Updegraff Clinic for Allergy & Dermatology, PC, or insurance company to release any information required to process my claims.

Patient / Guardian Signature _____ Date _____