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 / Mar / Div / Sep / Wid	
Primary language spoken?	Ethnicity:	Race:	Date of birth: / /	Age:	Sex: ❑ M ❑ F	
Street address (or P.O. Box):		Social Security No.:	Contact phone No.: ( )			
City:	State:	Zip Code:	Email Address:			
Occupation:	Employer:		Employer phone No.: ( )			

Referred to clinic by (please check one box): ❑ 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:

Subscriber's Name	Date of birth: / /	Address (if different):	Home phone No.: ( )
Employer:	Employer address:		Employer phone No.: ( )
Subscriber's S.S. #:	Date of birth: / /	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	
Policy #:		Group #:	

SECONDARY INSURANCE:

Subscriber's name:	Subscriber's S.S. #:	Date of birth: / /	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other
Policy #.:		Group #	

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 (If yes, with whom: _____)

In connection with medical services received, I consent and authorize Updegraff Clinic for Allergy and Dermatology ("The Clinic") 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*