Center for Advanced Dermatology

Adult Registration Form

❑New Patient ❑Update ❑Name Change ❑Address Change

Patient's Information:

Legal Name: _____ Date of Birth: _____ Age: _____
First Middle Last Month Day Year

Mailing Address: _____
Street /P.O. Box City State Zip Code

Primary Phone: _____ Work Phone: _____ Alternate Phone: _____
(Automated appointment reminder system calls **primary** number. ❑Check here if you do not want any reminder calls)

Gender_____ Name you prefer to be called by: _____

Primary Care Provider: _____ Who referred you to us: _____

Responsible Party's Information (party responsible for payment – please complete if different from Patient Information):

Name: _____ _____
First Last Address City State Zip Code

Home Phone: _____ Work Phone: _____ Alternate Phone: _____

Insurance Information (required for processing an insurance claim on your behalf):

Primary Insurance Carrier: _____ ID #: _____ Group #: _____

Name of Insured (Guarantor):_____ Date of Birth: _____ Relationship: _____

Employer: _____

Secondary Insurance Carrier: _____ ID #: _____ Group #: _____

Name of Insured (Guarantor):_____ Date of Birth: _____ Relationship: _____

Employer: _____

May we leave personal medical information on your answering machine? ❑Yes ❑No

Do you give our office permission to discuss your medical information with family members? ❑Yes ❑No

If yes, please provide their names and phone numbers below.

Name: _____Phone: _____Relationship: _____

Name: _____Phone: _____Relationship: _____

Emergency Contact Information:

Name: _____Phone: _____Relationship: _____

I understand that I will be responsible for any monies (deductibles, co-pays, etc.) due that are not paid by my insurance.

Patient Signature: _____Today's Date: _____

Please present your insurance card(s) and your photo identification to the receptionist. The receptionist will make a copy and return them to you promptly.
Thanks for your cooperation.