DERMATOLOGISTS OF SOUTHWEST OHIO, INC.

PATIENT REGISTRATION FORM

Today's date:	Account Number:

PATIENT INFORMATION

Patient's last name: First: Middle:	Race:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Home phone no.:	Cell phone no.:

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Family Physician:

Would you like to receive text message reminders? ❑ Yes ❑ No	Email:

How did you hear about us? ❑ Dr. _____ ❑ Insurance Plan _____ ❑ Friend _____ ❑ Location ❑ Advertisement ❑ Other

Other family members seen here:

BILLING INFORMATION

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Occupation	Employer:	Is patient covered by insurance? ❑ Yes ❑ No

INSURANCE INFORMATION

Name of primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Policy no.:	Group no.:	Specialist Co-pay: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Policy no.:	Group no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of tertiary insurance (if applicable):	Subscriber's name:	Policy no.:	Group no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone no.:	Work phone no.:

Authorization is hereby granted to Dermatologists of Southwest Ohio, Inc., its medical staff, and other personnel to obtain and release my insurance company and/or third party payor information, including medical records, as may be necessary for the completion of my present and future treatment claims. I hereby assign to the physician(s) all payment for medical services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by Insurance.

Patient/Guardian signature *Date*