



Schwarz Dermatology PLLC

1501 Lower State Rd • Suite 100 • North Wales, PA 19454

Initial Patient Registration Form

Patient's Name: _____ Date of Birth: _____

Who is your Primary Physician/Provider? _____

Referring Physician/Provider if different? _____

Have you been seen by Dr. Schwarz at any office location within the past 3 years? _____ YES _____ NO

Who is your Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Concerning matters of my health, lab results, and appointments, I, the patient/patient representative give permission for Dr. Schwarz or members of her staff to speak to and share my information with the above Emergency Contact:

_____ Yes _____ No

If you'd like us to share information with an additional or other contact, please provide the information below:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I ALLOW DO NOT ALLOW test results and other specific information regarding my care to be left on my answering machine or voicemail.

The above information is accurate 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 Schwarz Dermatology PLLC or insurance company to release any information required to process my claims.

Signature of Patient/Patient Representative: _____ Date: _____