DOYLESTOWN DERMATOLOGY REGISTRATION FORM

PATIENT'S NAME: _____ AGE:_____ BIRTHDATE:___/___/___

SOC. SECURITY #: _____ E-MAIL ADDRESS: _____

HOME ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ HOME PHONE: (____)_____ CELL PHONE: (____)_____

OCCUPATION: _____ BUSINESS ADDRESS: _____

BUSINESS PHONE: (___)_____ PHARMACY NAME AND PHONE NUMBER: _____

SPOUSE'S NAME (OR PERSON TO CONTACT IN CASE OF EMERGENCY):_____PHONE:_____

GUARANTOR (MUST SIGN BELOW AT THE BOTTOM OF THE PAGE, IF PATIENT IS A MINOR):

NAME: _____ SOC. SEC.#:_____ BIRTHDATE: ___/___/_____

RELATIONSHIP: _____ ADDRESS (IF DIFFERENT):_____ CITY: _____ STATE: ____ ZIP: _____

PERSONAL PHYSICIAN:_____

WERE YOU REFERRED TO THIS OFFICE? IF YES, WHO? _____

PRIMARY REASON FOR VISIT: _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING PROBLEMS?

☐ DIABETES	☐ PROBLEMS WITH HEALING	☐ GLANDULAR/ENDOCRINE PROBLEMS	☐ HYPERTENSION
☐ GI ULCERS	☐ LIVER DISEASE (INCLUDING HEPATITIS)	☐ ALLERGIES (E.G, HAYFEVER)	☐ ECZEMA
☐ ASTHMA	☐ BLEEDING (INCLUDING THE USE OF BLOOD THINNERS)	☐ HIV	☐ PSORIASIS
☐ GLAUCOMA	☐ KIDNEY DISEASE	☐ IMMUNOSUPPRESSION	

ALLERGIES TO MEDICATIONS? ___ IF YES, PLEASE LIST: _____

	YES	NO	EXPLAIN
DO YOU TAKE ANTIBIOTICS PRIOR TO SURGICAL PROCEDURES?	( )	( )	_____
ARE YOU IN GOOD GENERAL HEALTH?.....	( )	( )	_____
ARE YOU PREGNANT OR PLANNING PREGNANCY?.....	( )	( )	_____
ARE YOU SEEING A PHYSICIAN FOR ANY MEDICAL PROBLEMS?.....	( )	( )	_____
DO YOU HAVE A HISTORY OF SKIN OR OTHER CANCER?.....	( )	( )	_____
DO YOU HAVE A FAMILY HISTORY OF SKIN DISEASE OR SKIN CANCER?	( )	( )	_____
HAVE YOU HAD A RECENT SURGERY?.....	( )	( )	_____

LIST ALL MEDICATION YOU ARE NOW TAKING OR HAVE TAKEN IN THE LAST TWO MONTHS (INCLUDE SKIN & NONPRESCRIPTION MEDICATIONS): _____

PRIMARY INSURANCE CARRIER:_____ SECONDARY INSURANCE CARRIER:_____
NAME OF POLICY HOLDER: _____ RELATIONSHIP: _____
IF PATIENT IS NOT THE POLICY HOLDER, PLEASE COMPLETE THE LINE BELOW:
POLICY HOLDER'S DATE OF BIRTH: ___/___/___ POLICY HOLDER SOCIAL SECURITY #: _____

I REQUEST THAT PAYMENT OF INSURER BENEFITS BE MADE ON MY BEHALF TO DOYLESTOWN DERMATOLOGY, LLC., FOR SERVICES FURNISHED TO ME. FURTHERMORE, I HAVE AUTHORIZED TO RELEASE TO MY INSURANCE CARRIER(S) ANY AND ALL INFORMATION NEEDED TO DETERMINE BENEFITS PAYABLE FOR RELATED SERVICES. ALTHOUGH THE PROVIDERS OF DOYLESTOWN DERMATOLOGY MAY OR MAY NOT PARTICIPATE WITH MY INSURANCE CARRIER(S), I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY COPAYMENT, DEDUCTIBLES, OR UNPAID BALANCES.

SIGNATURE OF PATIENT OR GUARDIAN _____ DATE _____