



## New Patient Registration Form

Today's date:					PCP:						
<b>PATIENT INFORMATION</b>											
Patient's last name:			First:		Middle:		<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?			(Former name):			Birth date: / /		Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:					Cell phone no.: (    )			Home phone no.: (    )			
P.O. box:			City:			State:		ZIP Code:			
Chose clinic because/Referred to clinic by (please check one box):					<input type="checkbox"/> Dr. _____		<input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Website		
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work		<input type="checkbox"/> Yellow Pages		<input type="checkbox"/> Other					
Other family members seen here:											

<b>INSURANCE INFORMATION</b>					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:		Birth date: / /	Address (if different):		Home phone no.: (    )
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is this patient covered by insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Name of primary insurance :		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Name of secondary insurance (if applicable):		Subscriber's name:		Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					

<b>IN CASE OF EMERGENCY</b>				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone no.: (    )	Work phone no.: (    )
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 Complete Dermatology or insurance company to release any information required to process my claims.				
_____ <i>Patient/Guardian signature</i>			_____ <i>Date</i>	

Thank you for completing our New Patient Intake Form. Please click SUBMIT.