DERMATOLOGISTS OF CENTRAL STATES

REGISTRATION FORM

Name: _____ Preferred Name: _____
Last First MI

Birth Sex: M / F DOB: _____

Mobile Phone #: _____ Other (work/home) #:_____

Email: _____

Mailing Address: _____ City, State, Zip: _____

Preferred Pharmacy: _____ Address: _____

Primary Care Provider: _____ Phone #: _____

Referring Provider: _____ Phone #: _____

Do you authorize medical information regarding your care, test results, appointments, billing information, etc. to be shared with someone other than yourself? ☐Yes *(list below)* ☐ No

Name: _____ Phone #: _____

Name: _____ Phone #: _____

Emergency Contact: Full Name: _____ Phone #: _____

Is the Insurance Policy Under You (e.g., Subscriber)? ☐Yes ☐ No (If no, please give subscriber information below)

Subscriber Name: _____ Subscriber's Date of Birth: _____/_____/_____

Relation to Patient: ☐Parent ☐Spouse ☐Other_____

Do You Have Secondary Insurance Plan: ☐Yes ☐ No (If yes, see below question)

Is the Secondary Insurance Policy Under You (e.g., Subscriber)? ☐Yes ☐ No (If yes, please give subscriber information below)

Subscriber Name: _____ Subscriber's Date of Birth: _____/_____/_____

Relation to Patient: ☐Parent ☐Spouse ☐Other_____

Is Patient Under 18? ☐Yes ☐ No (If yes, please complete below financial guarantor information)

Guarantor Name: _____ Date of Birth: _____/_____/_____

Guarantor Address: _____ City, State, Zip: _____

Relation to Patient: ☐Parent ☐Spouse ☐Other_____