

GERMAIN DERMATOLOGY
NEW PATIENT REGISTRATION

Last Name, First Name _____ Middle Initial _____

Nickname _____

SSN#: _____ Date of Birth: _____ Age: _____

Sex: M / F Marital Status: S M D W Military: Y / N If yes, are you Retired? Yes No

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Contact Method: Cell phone _____ Home Phone _____ Work Phone _____

Email Address: _____ Can we send you email regarding specials and events? Yes No

Employer: _____ Occupation: _____

Guardian /Parent Name (if patient is under 18): _____

Guardian/Parent SSN#: _____ Guardian/Parent Date of Birth: _____

Spouse's Employer: _____ Spouse's Work Phone #: _____

Emergency Contact: _____ Phone Number: _____

Do you have a Primary Care Physician? Yes No
If so, who? _____ Phone Number: _____

Were you referred by a Physician to our practice? Yes No
If so, who? _____ Phone Number: _____

Primary Insurance: _____ Policy Holder's Name: _____

Policy Holder's SSN# (required): _____ Policy Holder's DOB (required): _____

Secondary Insurance: _____ Policy Holder's Name: _____

Policy Holder's SSN# (required): _____ Policy Holder's DOB (required): _____

PLEASE PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST

I hereby authorize the physician to provide information to insurance carriers concerning my medical care and I hereby irrevocably assign to the doctor all payments for all the medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as the original. I also give consent for my photo to be taken and used as part of my plan of treatment and confidential medical record.

Signature of Patient or Parent/Guardian: _____ Date: _____