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Dermatology Center of Williamsburg

PATIENT REGISTRATION FORM

Please PRINT CLEARLY to make sure all information will be entered correctly – *ALL AREAS MUST BE COMPLETED*

Date: _____/_____/_____

Social Security # _____ Date of Birth _____/_____/_____

Patient's Name (Last, First, MI) _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone: (____)_____ Cell Phone (____)_____ Work Phone: (____)_____

Email _____

Gender: M ○ F ○ Marital Status: S ○ M ○ W ○ D ○ Preferred Language: English ○ Spanish ○ Refuse to Report ○

Race: African American ○ Asian ○ American Indian ○ Native Hawaiian ○ Pacific Islander ○ White ○ Other ○ Refuse to Report ○

Ethnicity: Non-Hispanic ○ Hispanic ○ Refuse to Report ○

GUARANTOR INFORMATION

(Person financially responsible for bills when patient is under 18 years of age)

If information is same as patient, please check here:

Guarantor Name_____SS# _____DOB _____/____/_____

Address _____Contact Number: (____) _____

City _____ State _____ Zip _____

INSURANCE INFORMATION

Primary Insurance Name_____ Subscriber Name _____

Subscriber Identification # _____ Subscriber DOB _____/_____/_____

Patient's relationship to insured: Self ○ Spouse ○ Dependent Child ○ Other ○ _____

Secondary Insurance Name_____ Subscriber Name _____

Subscriber Identification # _____ Subscriber DOB _____/_____/_____

Patient's relationship to insured: Self ○ Spouse ○ Dependent Child ○ Other ○ _____

Information can be released to the following: (family member, friend, etc.)

Name _____ Relationship to patient _____

Phone Number: (____)_____

Date: _____/_____/_____ Patient / Responsible Party Signature _____