MD SkinCenter

Dermatology • Mohs • Facial Plastic Surgery

NEW PATIENT REGISTRATION FORM

Name: (First) ________ (MI) ________ (Last) ________ Today's date: ________

Date of birth: ________ Sex: Male ☐ Female ☐ Soc. Sec. #: ________

Address: ________

Phone: Home ________ Work ________ Cell ________

Preferred contact number: Home ☐ Work ☐ Cell ☐ Marital status: S ☐ M ☐ W ☐ D ☐

May we leave messages at your (check all that apply): Home ☐ Work ☐ Cell ☐ Email: ________

Employment status: Full-time/Part-time ☐ Unemployed ☐ Student Full-time/Part-time ☐ Retired ☐

Employer name: ________ Employer address: ________

Emergency contact: ________ Relationship: ________ Phone: ________

Referring physician: ________ Primary physician: ________

How did you hear about us? Radio ☐ Website ☐ Another patient ☐ Immediate care ☐ ER ☐ Other:

GUARANTOR INFORMATION (only complete this section if patient is under 18 years old)

Name: ________ Relationship to patient: ________

Address: ________

________ Soc. Sec #: ________

Phone: Home ________ Work ________ Cell ________

Email: ________ Marital status: S ☐ M ☐ W ☐ D ☐

Employer name: ________

Employer address: ________

Friend or relative not living with you: ________ Phone: ________

PHARMACY INFORMATION

Preferred pharmacy name: ________

Address: ________ Phone: ________

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

I authorize the release of any information required during the course of examination and treatment to third party payors and/or health care practitioners or their agents for the purpose of treatment, payment or practice operations. I authorize and request my insurance company to pay directly to Surgical Services of Illinois, SC, dba MD SkinCenter (MDS any benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for all charges incurred regardless of insurance coverage and to pay my bill in full for services rendered by MDS.

________ Signature of patient ________ Date

________ Print name

________ Signature of responsible party (if not the patient) ________ Date

________ Print name