SKIN
DERMATOLOGY

PATIENT REGISTRATION (Please Print) Today's Date ____/____/____

Name

____

Last First M.I.

Mailing Address ____

City State Zip Code

Home Phone________________________Cell Phone_______________________

Work Phone______________________

Date of Birth ____/____/____ Age_____ Sex_____ Marital Status ______

Email_______________________________________

Language

_____ English _____ Spanish _____ French _____ German _____ Vietnamese _____ Italian _____ Mandarin

PARENT OR RESPONSIBLE PARTY *(if different from patient)*

Name

____

Last First M.I.

Mailing Address ____

City State Zip Code

Home Phone________________________Cell Phone_______________________

Work Phone______________________

Date of Birth ____/____/____ Age_____ Sex_____ Marital Status ______

Email___________________________________

EMERGENCY CONTACT:

Name: ________________________ **Relationship**: _______________
Phone Number: ________________

Name: ________________________ **Relationship**: _______________
Phone Number: ________________

SKIN Dermatology
1950 45th St. Suite 200 Munster, IN 46321
219-912-DERM (3376)
www.skinmedsurg.com

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DERMATOLOGY

INSURANCE INFORMATION ***(Please present insurance card at time of check in.)***

Primary Insurance ___________________________

Ins. Address _________________________________

Name of Insured ________________________________

Insured's ID#____________________________________

Insured's SSN __________________________________

Group # ____

Insured's Date of Birth ___________________________

Employer Name _________________________________

Employer Address ______________________________

Employer Phone (_____)________________________

Relationship of patient to the Insured ______________

Secondary Insurance ______________________________

Ins. Address ____________________________________

Name of Insured _________________________________

Insured's ID# __________________________________

Insured's SSN __________________________________

Group #____

Insured's Date of Birth ____________________________

Employer Name _________________________________

Employer Address _______________________________

Employer Phone (____)___________________________

Relationship of patient to the Insured _______________

I have read and understand the financial and office policy of the practice and I agree to be bound by its terms. I hereby authorize SKIN Dermatology, LLC to collect financial information arising from my treatment. This includes, but is not limited to, hospital and laboratory services. I also understand and agree that such terms may be amended from time-to-time by the practice.

Patient **OR** responsible party signature
____Date____/____/_______

Please **print** the name of the patient____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician/provider.

Patient **OR** responsible party signature

____Date____/____/_______