DERMATOLOGY CENTER OF WORCESTER, LLC

PATIENT REGISTRATION

NAME (Last, First) _____

Addresses: Street: PO Box: _____

City, State: _____ Zip Code: _____

Best Phone Number: _____ Alternative Number: _____

Email: _____ Date of Birth: _____

Emergency Contact: ____ Spouse ____ Parent ____ Guardian ____ Child ____ Other

Contact Name: _____ Contact Phone: _____

INSURANCE INFORMATION

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

Relationship of Patient: _____

Preferred Pharmacy: _____ Primary Care Physician:_____

Is there anyone that you give permission for us to share your MEDICAL INFORMATION with? If so, please indicate their names below:

Name: _____ Relationship: _____

I understand that it is my responsibility to know my insurance coverage and that if for any reason my insurance does not cover any services, I will be responsible for the remaining balances.

Please sign and date below:

Signature: _____ Date: _____

ACKNOWLEDGEMENT AND CONSENT FOR HIPPA & NO SHOW POLICY

Signature: _____ Date: _____

Guardian (if under 18): _____ Date: _____