Bainbridge Skin Surgery
Consultative Dermatology

PATIENT REGISTRATION			
Patient Name		Date of Birth	Gender
Mailing Address		City & State	Zip
Home Phone	Work Phone	Cell Phone	Marital Status
E-mail		SSN	

OK to communicate via e-mail? ❑ Yes ❑ No **Note: I understand that e-mail may not be a secure means of communication.*

REFERRAL INFORMATION	
Referred By (Physician & Clinic)	Phone

PARENT, SPOUSE OR RESPONSIBLE PARTY *(IF DIFFERENT FROM PATIENT):*			
Name		Relationship	DOB
Mailing Address		City & State	Zip
Home Phone	Work Phone	Cell Phone	

INSURANCE INFORMATION

Please provide your insurance card(s) and driver's license (or other photo ID) to the receptionist.

	Primary Insurance	Secondary Insurance
Name of Insurance Company		
Name of Subscriber		
Subscriber's Relationship to Patient		
Subscriber's Date of Birth (if other than patient)		
Subscriber's Social Security No. (if other than patient)		
Policy / ID Number		
Group Number		

EMERGENCY CONTACT		
Name		Relationship
Home Phone	Work Phone	Cell Phone

The information provided is true to the best of my knowledge. I authorize treatment for myself or the above individual and I understand that I am ultimately responsible for charges associated with medical services and agree to pay all bills upon receipt of the statement, unless other arrangements are made. I authorize the physician to release to my Insurance and its agents any information required to process my insurance claims. I further agree that a copy of this agreement shall be as valid as the original. I authorize my insurance company to pay the provider directly.

Signature of Patient, Parent or Guardian: _____ **Date:** _____

Printed Name & Relationship (if other than patient): _____

**If signing as Power of Attorney, please provide a copy of Power of Attorney documentation.*