GERMAIN
DERMATOLOGY

NEW PATIENT REGISTRATION FORM

Last Name:	First Name:	M.I.
SSN:	Date of Birth:	Sex: Male ❒ Female ❒
Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed		Race:
Mailing Address:		
City:	State:	Zip:
Employer:	Occupation:	

Home Phone _____ -_____ -_____ Cell Phone_____ -_____ -_____

Work Phone _____ -_____ -_____ Email _____

By providing my wireless telephone number, I am consenting to receiving communications via calls or text messages including but not limited to information regarding appointments, payments, prescriptions, labs, and pathologies.

By providing my email address, I consent to receiving statements, bills, and marketing material for dermatology and cosmetic services via email.

Signature: _____ Date: _____

How did you hear about us?

- ○ Google
- ○ Social Media: _____
- ○ Patient/Physician: _____
- ○ Other Advertisement: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone: _____- _____- _____

Insurance Information:

Primary Insurance Name: _____
Policy Number: _____
Policy Holder's Name: _____
Policy Holder's DOB: _____

Secondary Insurance Name: _____
Policy Number: _____
Policy Holder's Name: _____
Policy Holder's DOB: _____

I hereby authorize the physician to provide information to insurance carriers concerning my medical care and I hereby irrevocably assign to the doctor all payments for all the medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as the original. I also give consent for my photo to be taken and used as part of my plan of treatment and confidential medical record.

Patient/Legal Guardian Signature: _____ **Date**: _____