Dermatology Associates of the South Bay

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NEW PATIENT REGISTRATION

Date: _____

Last Name: _____ First Name: _____ M.I.: _____ Sex: M / F

Birth Date: _____/_____/_____ Age: _____ Social Security #: _____-_____-_____

Address: _____
Street *City* *State* *Zip*

Email: _____*(to announce special events or promotional offers only)*

Phone: Home: ( ) Cell: ( ) Work: ( )

PLEASE CIRCLE THE BEST PHONE NUMBER TO REACH YOU ABOVE.

Occupation: _____ Employer_____

EMERGENCY CONTACT INFORMATION
Name of friend or relative (Preferably not living at the same address) _____

Contact Number: _____

Do we have permission to:

Leave a message on your answering machine?	Yes	No	(Please Circle)
Leave a message on your cell phone?	Yes	No	
Leave a message at work?	Yes	No	
Discuss your medical condition with anyone?	Yes	No	If yes, please give name:

_____

Do you have:

A history of Tuberculosis?	Yes	No	If yes, please explain
Night sweats?	Yes	No	
Fever	Yes	No	
Painful, swollen glands?	Yes	No	

How did you hear about us? : _____ (Please check one):
__ Doctor __ Insurance Plan __ Family Member __ Friend
__ Yellow Pages __ Internet __ Other: _____

INSURANCE INFORMATION

Subscribers Name: _____ Subscribers Birthdate:_____/_____/_____

Relationship to Subscriber (Circle): Self / Spouse / Child / Other
Primary Insurance Policy Name: Secondary Insurance Policy Name:

Policy Number: Policy Number:

I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for the services provided. I also authorize Dermatology Associates of the South Bay or my insurance company to release any information required to process my claim.

Patient / Guardian Signature: _____ Date: _____/_____/_____