DOCS
DERMATOLOGISTS
OF CENTRAL STATES

REGISTRATION FORM

(Complete Every 2 Years)

Name: ____ Preferred Name: ______________
Last First Middle

Email Address: ___________________________________ Have you used your Patient Portal? Yes No

Date of Birth: _____/_____/______ Birth Sex: □Female □Male Race: ______________________

Mobile Phone #: ________________ Home Phone #: ________________ Work Phone #: ________________
Preferred Phone: □Home □Work □Mobile

Home Address: ______________________________ City, State, Zip: ______________________________

Employer's Name: ____________________________ Occupation: ___________________________________

Emergency Contact: Full Name: __________________________ Phone #: __________________________

Do you authorize medical information regarding your care, test results, appointments, billing information, etc. to be shared with someone other than yourself? (If the authorized person/organization is not a healthcare provider, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.) □Yes *(list below)* □No
I also give consent to leave a message on my answering machine or voicemail? □Yes □No

Name: ____ Relation to Patient: ____________________

Name: ____ Relation to Patient: ____________________

Preferred Pharmacy: _____________________________ Address: _____________________________
Our office sends prescriptions electronically please list as much information as possible

Have you ever been seen by one of our providers? □Yes □No Provider Name: ______________________

Primary Care Provider: _________________________________ Phone #: __________________________

Referring Provider: ____________________________________ Phone #: __________________________

RESPONSIBLE PARTY/GUARANTOR □Same as Patient □Same as Policy Holder □Neither *(complete section below)*

Guarantor Name: ____ Date of Birth: _____/_____/_____

Guarantor Address: ____________________________________ City, State, Zip: _____________________

Relation to Patient: □Parent □Spouse □Other______________ Phone #: ____________________________

Employer: _________________________________ Employer Address: ______________________________

PRIMARY INSURANCE INFORMATION (*Please present insurance card to receptionist)*

Insurance Company Name: __________________________ Effective Date: ___/___/____ Group Number: __________

Policy Number: ______________ Policy Holder Name: _______________________ Date of Birth: ___/___/____

Relation to Patient: □Parent □Spouse □Other_________________ Phone #: _________________________

Subscriber Employer: ___________________________________ Employer Phone #: ____________________

SECONDARY INSURANCE INFORMATION (*Please present insurance card to receptionist)*

Insurance Company Name: __________________________ Effective Date: ___/___/____ Group Number: __________

Policy Number: ______________ Policy Holder Name: _______________________ Date of Birth: ___/___/____

Relation to Patient: □Parent □Spouse □Other_________________ Phone #: _________________________

Subscriber Employer: ___________________________________ Employer Phone #: ____________________