Advanced Dermatology & Skin Cancer Associates, PLLC
Patient Registration
Please Print

Patient Name: ______________________________, ______________________________, ________
Last Name First Name Middle Initial

Address: ____

________________, __________ ______________ Marital Status: □ Married □ Single □ Divorced □ Widowed
City State Zip Code

Date of Birth _____/_____/_____ Age: _________ Sex: __________ Social Security No:______________________

Home Phone # (_____)__________________ Work Phone #(_____)_________________ Cell #(_____)_________________

Email address:____________________________ Drivers License #:___________________ Occupation:____________________

Patient Employer: ____

Business Address:____

Responsible Party: ________________________________ Relationship to patient: ______________________________

How were you referred to our practice? □ Friend/Relative □ Hospital Referral □ Advertisement □ Physician ___________________

Are you interested in any cosmetic or laser treatment, if so ? ____

Spouse's/ Responsible Party Information:

Name: ______________________________, ______________________________, ________
Last Name First Name Middle Initial

Address: ____, ________________ ________ __________
City State Zip Code

Date of Birth ______/______/______ Social Security No:_________________________

Work Phone #(_____)_________________ Cell #(_____)_________________ Drivers License #:________________________

Insured Information:

Primary Insurance Company: ____

Policy Holder: ______________________________, __________________, ________ DOB: ______/______/______
Last Name First Name Initial

Insurance Company Address:______________________________, ________________________ ________ __________
Street City State Zip Code

Policy Number: ______________________ Group Number: _______________________ Effective Date:______________________

Co-Payment Required: _________________

Secondary Insurance Company: ____

Policy Holder: ______________________________, __________________, ________ DOB: ______/_____/______
Last Name First Name Initial

Insurance Company Address:______________________________, ________________________ ________ __________
Street City State Zip Code

Policy Number: ______________________ Group Number: _______________________ Effective Date:______________________

Co-Payment Required: _______________

To the best of my knowledge, the above information is complete and correct. I understand that my insurance coverage is a contract between myself and my insurance company and I take full responsibility for financial obligations incurred.

____ Date:__________________________
Patient Signature