VENICE DERMATOLOGY CLINIC, P.A.
PATIENT REGISTRATION FORM

Date: __________________________

Patient Name: ______________________________________ **Social Security Number** _____/_____/______

Date of Birth: ___________________ **Age:** ________ ☐ **Male** ☐ **Female**

Marital Status: ☐ **Married** ☐ **Wid** ☐ **Divorced** ☐ **Single** ☐ **Separated** ☐ **Other**

Local Address: ____

____

Phone Number: ______________________________ **Work Phone Number:** _________________________

Cell Phone Number: ___________________________ **Other:** _____________________________________

Email Address:____

Northern Address (If applicable):

____

____

Seasonal Phone Number:_______________________ ***Dates From:***_______________ ***To:***_______________

☐ **Employed** ☐ **Full time student** ☐ **Part time student** ☐ **Retired**

Spouse/Significant Other/Parent or Guardian:____

Employer/School:______________________________________

Emergency Contact Person:____

Emergency Contact Phone:__________________________ **Relationship:** ___________________________

Referred By: ☐ **Newspaper** ☐ **Ins. Company** ☐ **Physician** ☐ **Other(Please specify):**_______________

Primary Doctor:______________________________

Pharmacy Name:__________________________________ **Phone number:**___________________________

Pharmacy Address:____

PLEASE COMPLETE OTHER SIDE OF FORM

INSURANCE INFORMATION

Primary Insurance Company:____

Policy Holder Name (if different than patient): _______________________________________

Relationship to Patient:______________________________________ **DOB:**________________

Insurance Address:____

____

Policy ID Number:__________________________ **Group Name or Number:**__________________

Secondary Insurance Company:____

Policy Holder Name (if different than patient): _______________________________________

Relationship to Patient:______________________________________ **DOB:**________________

Insurance Address:____

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Policy ID Number:__________________________ **Group Name or Number:**__________________

Medicare Release Signature: I authorize any holder of medical or other information about me to be released to the Social Security Administration and the Center for Medicare and Medicaid Services or its intermediaries or carriers, and my Medicare supplemental insurance carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Venice Dermatology Clinic, PA.

____ ____________________

Patient/Parent Signature **Date**

Financial Policy: Claims will be forwarded to your insurance carrier for processing. I understand that co-pays and deductibles are collected at time of service and that I am responsible for any collection costs for non-payment, should action become necessary.

____ ____________________

Patient/Parent Signature **Date**

PLEASE PRESENT YOUR INSURANCE CARD(S) AND PHOTO ID TO RECPTION