ACDA
aesthetic and clinical dermatology associates

PATIENT REGISTRATION FORM

Patient Information

Last Name: _____ **First Name:** _____**MI**____ **Preferred Name**: _____

Date of Birth: _____/_____/_____ **Sex (Circle)**: M F **Social Security #**:__ __ __-__ __-__ __ __ __ **Credentials:** _____

Primary Language: _____ **Marital Status: S M W D Other** **Ethnicity (Circle)**: Hispanic or Latino Not Hispanic or Latino

Race (Circle): African American/Black American Indian/Alaska Native Asian Caucasian/White Native Hawaiian/Pacific Islander Other

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

Home Phone #: (____) _____-_____ **Ok to leave voice message**: YES NO **Work Phone #**: (____) _____-_____

Cell Phone #: (____) _____-_____ **Ok to leave voice message**: YES NO **Ok to send text message**: YES NO

Primary Phone #: (____) _____-_____ **Ok to leave voice message**: YES NO **Ok to send text message**: YES NO

E-Mail Address: _____ **Ok to email appointment reminders**: YES NO

Preferred Communication (Circle): Home Cell Work Text Email **Emergency Contact:** _____

Relationship: _____ **Home Phone #**: (____) _____-_____. **Cell Phone #**: (____) _____-_____.

Preferred Pharmacy: Name _____ **Location** _____ **Phone #** _____

Responsible Party (If patient is a minor, person who brought minor to the office)

Last Name: _____ **First Name:** _____**MI**____ **Preferred Name**: _____

Date of Birth: _____/_____/_____ **Sex (Circle)**: M F **Social Security #**:__ __ __-__ __-__ __ __ __ **Credentials:** _____

Primary Language: _____ **Marital Status: S M W D Other** **Ethnicity (Circle)**: Hispanic or Latino Not Hispanic or Latino

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

Home Phone #: (____) _____-_____ **Work Phone #**: (____) _____-_____ **Cell Phone #**: (____) _____-_____.

Primary Phone #: (____) _____-_____ **E-Mail Address**: _____

Relationship to Patient: Self Parent Spouse Other_____

Insured Person Information (If different than patient information)

Last Name: _____ **First Name:** _____**MI**____ **Preferred Name**: _____

Date of Birth: _____/_____/_____ **Sex (Circle)**: M F **Social Security #**:__ __ __-__ __-__ __ __ __ **Credentials:** _____

Primary Language: _____ **Marital Status: S M W D Other** **Ethnicity (Circle)**: Hispanic or Latino Not Hispanic or Latino

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

Home Phone #: (____) _____-_____ **Work Phone #**: (____) _____-_____ **Cell Phone #**: (____) _____-_____.

Primary Phone #: (____) _____-_____ **E-Mail Address**: _____

Relationship to Patient: Self Parent Spouse Other_____

Assignment and Release

My signature below authorizes the release of medical information to my primary care physician, and as necessary for the processing of insurance claims and prescriptions. I authorize payment of medical benefits to the doctor when an assigned claim is filed. I authorize payment of medical benefits to the physicians of this office. I also understand payment is expected at the time of service (all co-pays and balances due must be paid when the service is given). By signing this form, I acknowledge that I have received ACDA's Financial Policy and am aware that it can change at any time.

_____ _____ _____

Patient Signature Parent Signature (if patient is a minor) Date