Hartford Dermatology Associates, P.C. • Pediatric Dermatology of New England

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Patient Registration Form

Please complete all of the requested information below.

Patient Information:

Name _____ **DOB** _____

Address _____

City, State, ZIP _____

Telephone: Home _____ **Work** _____ **Cell** _____

Sex _____ **Marital Status** _____ **Birthdate** _____

Occupation: _____

Employer: _____

Town: _____

Primary Care Physician or Pediatrician:

Name _____ **Town** _____

Parents' Names and Dates of Birth (If Patient is a Child) :

Name _____ **DOB** _____

Name _____ **DOB** _____

Insurance Subscriber's Name _____

Subscriber's Date of Birth _____ **Sex** _____

Address (if different) _____

2nd Insurance (if applicable) _____

******* PLEASE PRESENT INSURANCE CARDS FOR COPIES *******

I authorize the release of any information to the insurance company, on myself or my child, which is necessary to process my medical claim. I also authorize payment directly to Hartford Dermatology Associates and understand I am responsible for any co-payments, co-insurance, deductibles, etc. I have also reviewed a copy of the Notice of Privacy Practices for this office.

_____ _____

Please Print Patient's Name **Signed**

_____ _____

Date **Relationship to patient, if different**