Hartford Dermatology Associates Patient Registration Form

PATIENT INFORMATION

Patient's Full Name:_____ Date of Birth:_____

Address:_____ City:_____State:_____ Zip:_____

Sex:_____ Marital Status:_____ Email address:_____

Home Phone:_____ Cell phone:_____Work Phone:_____

Please circle your preferred phone number. Is it OK to leave a detailed message if necessary? Yes No

Pharmacy Name and Address:_____

Employer:_____ Occupation:_____

Primary Care Physician:_____Address:_____

Primary Insurance:_____ Policy Holder Name:_____

Relationship to Patient:_____ Date of Birth:_____

Secondary Insurance:_____Policy Holder Name:_____

Relationship to Patient:_____ Date of Birth:_____

RESPONSIBLE PARTY (FOR MINORS UNDER 18 YEARS OLD)

Full name:_____ Date of Birth:_____

Address (if different)_____

Primary Insurance:_____ Secondary Insurance:_____

PLEASE PRESENT INSURANCE CARD FOR COPIES

I authorize the release of any information to the insurance company, pertaining to myself or my child, which is necessary to process my medical claim. I also authorize payment directly to Hartford Dermatology Associates and understand that I am responsible for any copayments, co-insurance, deductibles, etc. I acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the waiting room, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

Printed Name:_____ Date:_____

Signed:_____ Relationship to patient:_____

Patient refused to sign: Y N Patient was unable to sign because:_____