Pacific Dermatology INSTITUTE

Pacific Plastic Surgery and LASER CENTER

PATIENT REGISTRATION FORM

Please PRINT. All information must be completed. If not applicable, please mark N/A.

Name: Last, First, MI: _____ Gender: _____

If minor, Responsible Parent Name: _____ Date of Birth: _____

Marital Status: ○ Married ○ Divorced ○ Single ○ Widowed ○ Separated SSN#: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Contact Method for appointment reminder: ○ HOME ○ CELL

How did you hear about us: _____ Email address: _____

Would you take part in a survey about our practice in order to better serve you ○ YES ○ NO

Employer: _____ Occupation: _____

Primary Care Physician Name: _____ PCP Phone #: _____

Referring Physician Name (if different from above): _____ Ref Phys #: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Preferred Pharmacy: _____ Phone # _____ Cross Streets: _____

Race: _____ Language _____ Ethnicity: _____ Decline to Answer ○

MEDICAL INSURANCE INFORMATION

Primary Insurance: _____ Patient Policy # _____

Group Name or Number _____ Claims Address: _____

Insured Party's Name: _____ Insured's DOB: _____

Relationship to Insured: Self / Spouse / Child / Other _____ Insured's SSN#: _____

Secondary Insurance: _____ Patient Policy # _____

Group Name or Number _____ Insured Party's Name: _____

Insured's DOB: _____ Relationship to Insured: Self / Spouse / Child / Other _____ Insured's SSN#: _____

I acknowledge that the information provided is complete and accurate.

_____ _____ _____

(Signature of Patient or responsible party) Printed Name Date

OFFICE USE ONLY

Primary _____ ID# _____ Medical Group _____ Copay _____

Secondary _____ ID# _____ Medical Group _____ Copay _____