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: _____

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

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

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

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

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

Preferred contact method for appointment reminder: ◯ Home ◯ Cell ◯ Text ◯ Email ◯ None

Would you like to register for the patient portal: ◯ Yes ◯ No

Would you like to receive emails regarding special events, discounts, and cosmetic services: ◯ Yes ◯ No

After your visit you may receive a patient satisfaction survey via text, email or paper. We kindly ask that you complete this survey.

Employer: _____ Occupation: _____

Primary Care Physician Name: _____ PCP Phone #: _____

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

Emergency Contact: _____ Relationship: _____ Phone #: _____

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