

## Patient Registration Form

**Welcome! Thank you for choosing Ocean State Dermatology.**  
**Please completely fill out this form to ensure the fastest and best healthcare service.**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Sex: M \_\_\_ F \_\_\_ Marital Status: Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Widow \_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: ( ) \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Email: \_\_\_\_\_ May we send information here? (circle one) YES NO  
Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_  
Employer: \_\_\_\_\_ Years There: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

*Complete this section only if someone other than the patient is financially responsible:*

Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: ( ) \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Employer: \_\_\_\_\_ Years There: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of Spouse: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_  
Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_  
Employer: \_\_\_\_\_ Years There: \_\_\_\_\_ Employer's Telephone: ( ) \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

How did you learn about our practice? (friends, family, internet, website, other) \_\_\_\_\_

Name & Address of Primary Care Physician: \_\_\_\_\_

Name of Referring Physician (if different from Primary Care Physician): \_\_\_\_\_

Do you wish for correspondence to be confidential? (circle one)      YES    NO

Do you wish for phone calls to be confidential? (circle one)      YES    NO

May we contact you at work? (circle one)      YES    NO

If you would like us to discuss your personal health information such as results with someone other than yourself, please indicate below

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**INSURANCE INFORMATION:**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

PRIMARY INSURANCE:

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy ID #: \_\_\_\_\_

SECONDARY INSURANCE:

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy ID #: \_\_\_\_\_

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

Method of Payment for Today's Visit: (circle one)    Cash    Check    VISA/MC/Discover

Signature of Patient or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize the release of any medical information necessary to process my claim.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(patient or responsible party)

I authorize payment of medical and surgical benefits to \_\_\_\_\_, MD.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(patient or responsible party)