

**SCHABERG DERMATOLOGY
REGISTRATION
Please Print and Complete All Sections**

PATIENT INFORMATION

Today Date _____

Name: _____ Sex: _____
Last First M.I.

Address: _____ Marital Status _____
Number Street City State Zip

Date of Birth: ___/___/___ SSN#: _____ Home #: _____

Work #: _____ Cell #: _____ (Please don't list a minors cell#)

Employer: _____ Retired?: _____ Full Time Student: _____

Person to notify in case emergency: _____ PCP or Referring Physician: _____

(Please list a person Not living in your home)

Phone# _____

Which phone number should we call first ? Home ___ Work ___ Cell ___ (Please put an X on appropriate line.)

May we leave a message on your home answering machine? Yes ___ No ___

May we leave a message at your work to call us? Yes ___ No ___

May we discuss your medical condition with another person? Yes ___ No ___

If yes, Whom may we speak with _____ Relationship _____

Preferred pharmacy (Name, Location and Phone # _____)

Primary Insurance Guarantor Information

Name: _____ Date of Birth: ___/___/___ Relationship to Patient _____
Last First MI

Home Address: _____
Number Street City State Zip

SSN: _____ Home #: _____ Work # _____ Cell # _____

Insurance Company: _____ ID #: _____ Group #: _____

Secondary Insurance Guarantor Information

Name: _____ Date of Birth: ___/___/___ Relationship to Patient _____
Last First MI

Home Address: _____
Number Street City State Zip

SSN: _____ Home #: _____ Work # _____ Cell # _____

Insurance Company: _____ ID #: _____ Group #: _____

Is the patient a minor? Yes No (If yes, the accompanying adult must fill out below.)

Name: _____ SSN# _____ Relationship to patient _____

Please present insurance card and Driver's License to the receptionist for copies to be made
Copays, Deductibles, and co-insurance must be paid at check-in