DERMATOLOGY OF SOUTHERN KENTUCKY, PLLC

PATIENT REGISTRATION FORM

(Please Print)

Pharmacy:		**Family Doctor:**		**Telephone#:**	

PATIENT INFORMATION

Patient's Full Name:		❑ Female ❑ Male		**Marital status (Circle One):** **Single / Mar / Div / Sep / Wid**	
Is this your legal name? **❑ Yes ❑ No**	**If not, what is your legal name?**	**(Former name):**	**Birth date:** / /	**Age:**	
Street address:		**Social Security no.:**		**Home phone :** **Cell phone:**	
P.O. box:	**City:**		**State:**	**ZIP Code:**	
Occupation:	**Employer:**			**Employer phone : ( )**	
Referred to clinic by (please check one box):		❑ Dr.		❑ Insurance	❑ Hospital
❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other	
Other family members seen here:					

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	**Birth date:** / /	**Address (if different):**	**Home phone :** ( )
Is this person a patient? ❑ Yes ❑ No			
Occupation:	**Employer:**	**Employer address**:	**Employer phone :** ( )

Is this patient covered by insurance?	❑ Yes	❑ No			
Please indicate primary insurance	❑ Medicare	❑ Medicaid	❑ Humana	❑ Anthem BCBS	❑ United Healthcare
❑ Bluegrass Family	❑ Tricare	❑ RR Medicare	❑ Unicare	❑ Other	

Subscriber's name:	**Subscriber's S.S. no.:**	**Birth date:** / /	**Group no.:**	**Policy no.:**	
Patient relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	**Subscriber's name:** **Birth Date:**		**Group no.:**	**Policy no.:**	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name of local friend or relative:	**Relationship to patient:**	**Home phone no.:** **( )**	**Work phone no.:** **( )**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the practice or insurance company to release any information required to process my claims. I agree that my informed consent may be obtained verbally if office procedures (biopsy, cryosurgery, destruction, excision, repair, etc) are indicated. I understand that pathology (biopsy) services are performed by another entity and that I and/or my insurance will be billed separately.

_____ _____

Patient/Guardian signature ***Date***