DERMATOLOGY PARTNERS OF WNY, LLP

DATE:_____

PATIENT REGISTRATION FORM

PATIENT NAME _____ Date of Birth: _____ **SEX** M F
(Last) (First) (Middle)

ADDRESS _____
(STREET) (APT) (CITY) (STATE) (ZIP)

PREFERRED CONTACT (_____)_____WORK PHONE (_____)_____

CELL PHONE (_____)_____ HOME PHONE (_____)_____

RACE/ ETHNICITY (*PLEASE CIRCLE*): WHITE BLACK OR AFRICAN AMERICAN AMERICAN INDIAN OR ALASKAN NATIVE

ASIAN NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER HISPANIC OTHER_____

MARITAL STATUS *(PLEASE CIRCLE)*: MARRIED SINGLE WIDOWED DIVORCED

LEGALLY SEPARATED DOMESTIC PARTNER

EMPLOYMENT STATUS (*PLEASE CIRCLE*): DISABLED RETIRED NOT EMPLOYED

EMPLOYER _____ STUDENT (FT OR PT)
EMP STATUS: FT PT

PRIMARY CARE PHYSICIAN (FULL NAME) _____

ADDITIONAL PROVIDER YOU WISH TO RECEIVE CORRESPONDENCE_____

INSURANCE INFORMATION *Please complete below and bring cards to appt.*

PRIMARY INSURANCE_____ ID #_____

POLICY HOLDER_____ **DOB**_____RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE_____ ID #_____

POLICY HOLDER_____ **DOB**_____RELATIONSHIP TO PATIENT_____

RESPONSIBLE PARTY INFORMATION *Complete if patient is not the responsible party or if patient is a minor*

RESPONSIBLE PARTY _____

ADDRESS _____
(STREET) (APT) (CITY) (STATE) (ZIP)

AUTHORIZATION FORM (For Medicare Only)

_____ _____
Name of Beneficiary Health Insurance Claim Number

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dermatology Partners of Western New York, LLP for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
Patient Signature Date