

REGISTRATION FORM

Contact Information

Patient Name _____ Preferred Name _____ Date _____

Marital Status _____ SSN _____

DOB _____ Birth Sex **M** **F**

Mobile Phone Number _____ Other Phone Number _____

May we leave a detailed message on your voicemail? **Y** **N** Email Address _____

Mailing Address _____

Apt, Unit, etc. _____ City _____ State _____ Zip Code _____

Employer Name _____

Emergency Contact Name _____ Emergency Contact Phone Number _____

Guarantor/Responsible Party Information - If the patient is under 18, please fill out the following information:

Note: we do not bill absent parents. The adult presenting the minor for care is the responsible party.

Guardian Name _____ Guardian DOB _____

Mailing Address _____ City _____

State _____ Zip Code _____

Mobile Phone Number _____ Other Phone Number _____

Authorization for Disclosure of Protected Health Information

Would you like to authorize Bahr Dermatology to share your health information with another person? **Y** **N**

If **YES**, whom? _____ Relationship to Patient _____
(print name here)

Phone Number _____

Specify information to be released: Entire Medical Record Medical Record from _____ to _____
(date) (date)

Medical Record Pertaining to _____

Signature of Patient or Authorized Representative: _____

Insurance Information

Please fill out the following information in its entirety to avoid claim denials by your insurance.

Primary Insurance Payer _____

Policy #/Member ID # _____ Group # _____

Patient's Relationship to Policy Holder Self / Spouse / Child / Other

Policy Holder Name _____ Policy Holder DOB _____

Policy Holder Address (if different than your own) _____

Secondary Insurance Payer _____

Policy #/Member ID # _____ Group # _____

Patient's Relationship to Policy Holder Self / Spouse / Child / Other

Policy Holder Name _____ Policy Holder DOB _____

Policy Holder Address (if different than your own) _____