



B a h r D e r m a t o l o g y
460 S. 200 W
Bountiful, UT 84010

PATIENT REGISTRATION FORM

Name Last First M.I. Today's date

Mailing Address Number, Street, Apartment Number Age

City State Zip

Home Phone () Work Phone () Cell Phone ()

E-Mail

Date of Birth / / SS # Marital Status Gender

Employer Retired Full Time Student Part Time Student

Spouse's Name: Employer Work #

Person to notify in case of emergency Phone (Please list a person not living in your home)

Referring Doctor

May we leave a message on your home answering machine? Y N
May we leave a message for you at work to call us? Y N
May we discuss your medical condition with another person? Y N

If yes, whom Relationship

How did you hear about our practice?

Policy Holder (if different from patient or responsible party)

Policy Holder's Date of Birth / / SS#

Employer of Policy Holder Work Phone()

Patient's Relationship to Policy Holder

If patient is a minor please enter responsible party information. (Note: We do not bill absent parents, the adult presenting the minor for care is the responsible party.)

Name Last First M.I. SS#

Mailing Address Number, Street, Apartment Number

City State Zip

Home Phone () Work Phone () Cell Phone ()

PLEASE PRESENT THIS FORM WITH YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST