SOUTH SHORE DERMATOLOGY PHYSICIANS, P.C.
Patient Update/Registration Form

Name:_____
Last First Middle Initial

Address:_____
Street City State Zip Code

Date of Birth:_____ Age:_____ Sex:_____ Social Security #_____
Marital Status:_____ Living Arrangements: Alone Family Roommates Spouse/significant other

Home Phone:_____ Work Phone:_____ Cell Phone:_____
OK to leave messages at (please check all that apply): Home_____ Work_____ Cell_____

Email:_____ Occupation: _____
Employer's Name:_____ Employer's Address:_____

In case of an Emergency, who should be contacted?_____ Phone #_____

Referred by:_____

Primary Care Physician: _____
Last First Telephone #

Pharmacy of Choice:_____
Name Address Telephone #

Do you give our office permission to discuss your medical, billing or scheduling information with family members? ☐ YES ☐ NO If YES, please provide their names and phone numbers below.
Name_____Relationship_____Phone#_____
Name_____Relationship_____Phone#_____

INSURANCE INFORMATION (PLEASE PRESENT YOUR INSURANCE CARD(S) TO THE RECEPTIONIST)

Primary Insurance Company Subscriber Name/D.O.B. Relationship to Subscriber

Secondary Insurance Company Subscriber Name/D.O.B. Relationship to Subscriber

Other Insurance Information

RESPONSIBLE PARTY INFORMATION

Name of Person Responsible Address Phone #

Relationship to Patient

Please Note:
I hereby give my consent to be treated by my dermatologist here at South Shore Dermatology Physicians, P.C. Additionally, I authorize the release of any medical reports, findings and treatment plans to my physician and insurance company, as well as other information necessary to process my insurance claim. I also request payment of government benefits either to myself or to the party who accepts assignment. *I understand that South Shore Dermatology Physicians, P.C. will bill my insurance, when applicable, for services rendered, but I will be responsible for any balance resulting from a deductible, copayment, co-insurance or non–covered service(s) performed.* If you were referred by your primary care physician or other healthcare provider, we will send a written report of our findings and treatment plan to that person, as well as periodic updates. (Your managed care plan requires that we do so). Please sign below to authorize the release of this information.

_____
Patient Signature/Date Signed

ALLERGIES