PINNACLE
DERMATOLOGY

Patient Registration Form

Today's Date: _____

Patient Information

Legal Last Name, Legal First Name, Legal MI		Date of Birth
Street Address		City, State, Zip Code
Home Phone	Cell Phone	Work Phone
Email Address		Social Security Number
Gender		Marital Status (Married, Single, Other)

If minor provide the Full Name and mailing address (if different than patient) of the Financial Responsible Person

Emergency Contact

**This contact will be used only in case of an emergency

Name	Phone Number	Relationship

Primary Insurance Information

Name of Policyholder	Policyholder DOB	Relationship to Patient
Name of Insurance Company & Product Type		Employer Name
Insurance ID	Group Number	
Policyholder's Gender	Policyholder's Address (if different than patient)	

Secondary Insurance Information

Name of Policyholder | Policyholders DOB | Relationship to Patient

Name of Insurance Company & Product Type | Employer Name

Policyholder's Gender | Policyholder's Address (if different than patient)

How were you Referred to Us?

- ☐ Direct Mail
- ☐ Doctor Referral
- ☐ Email Newsletter
- ☐ Google
- ☐ Insurance Company
- ☐ Local Community Event
- ☐ Newspaper
- ☐ Online Advertisement/Social Media
- ☐ Patient Referral
- ☐ Pinnacle Website
- ☐ Skin Cancer Screening
- ☐ Yellow Pages
- ☐ Other: _____

Primary Care Physician

PCP Name | Address | Phone Number

Referring Physician

Referring Physician Name (if different than PCP) | Address | Phone Number

Authorization & Consent

I authorize my insurance company(ies) to pay benefits directly to my provider. I hereby consent to the release of medical information, including electronic means, necessary to process any insurance claims and to any other doctor for the continuation of my medical care. The information I have provided above is accurate to the best of my knowledge. I accept personal responsibility for any and all services in which I have been proven ineligible for medical benefits. I have read and received "FINANCIAL POLICY FOR PINNACLE DERMATOLOGY, SC." I understand a photocopy of this release is as valid as the original. You may receive a signed copy upon your request. I give permission to Pinnacle Dermatology, SC and its agents to contact me at any cell phone numbers provided.

I certify I have completed this form in its entirety, and the above is true and correct.

Patient/Authorized Representative Signature | Date

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Patient Name (Printed)