Patient Registration Form

Name: _____ DOB: _____ Sex: M / F **SSN: _____**

Address, City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Emergency Contact: _____

Who referred you to this office: _____ Primary Physician: _____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. Payment is expected from you at the time of service. We accept major Credit Cards (Visa, Discover, MasterCard, and American Express), Personal Checks, and Cash for your convenience. Your signature below indicates that you understand this policy and accept full responsibility for any charges incurred by you in this office. Further, your signature authorizes Southeastern Dermatology to release any medical information necessary to process your insurance claims. You herein authorize payment of medical benefits to Southeastern Dermatology when an assigned claim is filed. This is a lifetime authorization.

Signature: _____ Date: _____

During your visit today or on future visits it may be necessary for you to have a skin biopsy, cryotherapy (liquid nitrogen) or other minor procedures for the treatment of your skin condition. Potential risks include scarring, bleeding, and infection. Please indicate by signing below that you understand and consent to these treatments.

Signature: _____ Date: _____

Medical, Family, & Social History

Current Medications: _____

Allergies/Reactions to Medication: _____

General Health (Circle One): Excellent Good Fair Poor

Has Any Close Relative (Parent, Sibling, Child) Been Diagnosed with the Following? Circle All that Apply):

Melanoma Other Skin Cancer Asthma Hay Fever Eczema Lupus Psoriasis

Do You Drink Alcohol? Yes / No **If So, How Many Times Per Week? ____ Smoke?** Yes / No

Pharmacy Information

Pharmacy Name: _____ Phone: _____

Address: _____