Dermacenter MD
Advanced Dermatology & Aesthetic Solutions

Registration Form

MRN: _____

Established Patient: ☐Yes ☐ No

Patient Information:

_____ Suffix: _____
First (Legal) Middle Last

Sex:☐M ☐F Marital Status: _____ Date of Birth:_____/_____/_____ Social Security # _____

Preferred Language: _____ Race/Ethnicity: _____

Patient's
Address: _____ Apt.#: _____
Street # Street Name

_____
City State Zip

Landline: (_____)_____ Work: (_____) _____ Cell: (_____)_____

Preferred Contact Number: ☐ Landline ☐ Work ☐ Cell Is it ok to leave a detailed message? ☐ Yes ☐ No

Email Address: _____ Would you like to receive text messages? ☐ Yes ☐ No

Please List with Whom We May Discuss Your Medical Information and/or Notify in Case of Emergency:

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

Insurance Information: Do you have insurance? ☐Yes ☐ No Do you have Medicaid? ☐Yes ☐ No

Primary Insurance Carrier: _____ Policy Holder: Self ☐ Other (answer below)

Secondary Insurance Carrier: _____ Policy Holder: Self ☐ Other (answer below)

Policyholder's Information (if Other than Patient):

Name: _____ ☐Jr. ☐ Sr.
First Middle Last

Date of Birth: _____ / _____ / _____ Sex: ☐M ☐F Social Security # _____

Relationship to Patient: _____ Employer: _____

Billing Address (If Different from Above):

_____ Apt.#: _____
Street # Street Name

_____
City State Zip

Preferred Pharmacy:

Pharmacy Name: _____ Pharmacy Address: _____

City: _____ State: _____ Zip Code: _____

Is it ok to obtain your prescription history? ☐ Yes ☐ No

Primary Doctor: _____ Referring Doctor: _____

Signature:_____**Date:**_____

111 North Nappanee St, Elkhart IN 46514 Phone: (574) 522-0265