WESTERN DERMATOLOGY CONSULTANTS, P.C.

REGISTRATION FORM

THE INFORMATION REQUESTED ON THIS FORM IS USED TO FILE MEDICAL CLAIMS AND FOR OTHER IMPORTANT MEDICAL DOCUMENTATION. PLEASE PRINT LEGIBLY SO THAT WE MAY ACCURATELY REFLECT YOUR PERSONAL INFORMATION IN ANY TRANSACTION WE MAY NEED TO MAKE ON YOUR BEHALF. THIS INCLUDES CALLING YOUR INSURANCE COMPANY, SENDING REQUISITIONS TO LABS, etc.
THANK YOU

Referring or Primary Care Physician: (**FIRST AND LAST NAME**)

PATIENT INFORMATION

Patient's last name:	First:	Middle Int:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name? **THIS IS REQUIRED FOR FILING AN INSURANCE CLAIM***	Preferred/Nickname:	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:

City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )	Home phone no.: ( )	Cell phone no.: ( )

INSURANCE INFORMATION

PLEASE PROVIDE RECEPTIONIST WITH YOUR INSURANCE CARD(S)

Please indicate **primary** insurance company name:	

Subscriber's name: ***REQUIRED*** **This is the person who carries the policy.**	Subscriber's S.S.#:	D.O.B.: ***REQUIRED***	**IN ORDER FOR THE WDC TO FILE A CLAIM ON YOUR BEHALF, THE INFORMATION ASKED HERE IS REQUIRED. WITHOUT THIS INFO, WE WILL NOT BE ABLE TO BILL YOUR INSURANCE COMPANY, MAKING YOU A SELF PAY PATIENT**
		/ /	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of **secondary** insurance (if applicable):	Subscriber's name:	D.O.B.: / /	

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Person responsible for bill: ***REQUIRED***	D.O.B.: ***REQUIRED*** / /	Address (if different):	Home phone no.: ( )

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Western Dermatology Consultants, P.C. or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Allergic To: ______________________ ______________________ ______________________