MAGNOLIA
DERMATOLOGY

PATIENT REGISTRATION FORM

Patient Information: Today's Date:_____

Last Name: _____ First Name:_____ Middle Initial:_____

Preferred Name: _____Date of Birth: _____ SSN: _____

Gender: ☐ Male ☐ Female Marital Status: _____

Employment:

Employer: _____ Occupation: _____

Contact Information:

Home: _____ Work: _____

Mobile: _____ Email: _____

**HOW WOULD YOU LIKE TO RECEIVE YOUR APPOINTMENT REMINDERS? PLEASE CHECK ALL THAT ARE PREFERRED. PHONE/VOICE ☐ E-MAIL☐ TEXT☐

Mailing Address:

Address:

_____

City: _____ State: _____ Zip: _____

*Responsible party's mailing address if different from physical: _____

_____

Emergency Contact:

Name: _____ Phone: _____

Relationship to patient:

_____

Insurance Information:

Insurance Co. Name: _____ Policy ID#: _____

Group #: _____**Insured's SSN**: _____ **Insured's DOB:** _____

Name of Insured: _____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

PATIENT REGISTRATION FORM (Continued)

Secondary Insurance Information:

Insurance Co. Name: _____ Policy ID#: _____

Group #: _____ Insured's SSN: _____ Insured's DOB: _____

Name of Insured: _____

Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

Primary Care Physician:

Physician Name: _____ Phone: _____

Address:_____

City: _____ State: _____ Zip: _____

I hereby sign all medical and/or surgical benefits to Magnolia Dermatology, LLC. This includes major medical benefits, Medicare and Government sponsored programs, private insurance or other.

I understand that I am responsible for all applicable copayments, coinsurance, and non-covered services, as required by my insurance policy. All Cosmetic Procedure balances are due in full at the time of service.

I hereby authorize Magnolia Dermatology, LLC, to release all information necessary, including medical records to secure the payment of insurance benefits.

Signature: _____ Date: _____