SOUTHSIDE DERMATOLOGY
& LASER COSMETIC CENTER

Patient Registration Form

THIS PATIENT INFORMATION FORM IS PART OF YOUR MEDICAL RECORD AND MUST BE COMPLETED IN ITS ENTIRETY.

NAME ____
(LAST) (FIRST) (MIDDLE)

SSN: ____________________ DOB: ________________ SEX: M F MARITAL STATUS: S M D W

HOME ADDRESS: ____
(STREET) (APT) (CITY) (STATE) (ZIP)

HOME PHONE ____________________ EMAIL ____________________

WORK PHONE ____________________ CELL PHONE ____________________

OCCUPATION ____________________ EMPLOYER ____________________

RESPONSIBLE PARTY INFORMATION: (IF OTHER THAN PATIENT)

NAME ____
(LAST) (FIRST) (MIDDLE)

RELATIONSHIP TO PATIENT: ____________________ SSN OF INSURED: ____________________

DOB OF INSURED: ____________________ PHONE: ____________________

HOME ADDRESS: ____
(STREET) (APT) (CITY) (STATE) (ZIP)

☐ I HAVE NO INSURANCE COVERAGE (PLEASE CHECK IF APPROPRIATE)

Do we have your permission to:

Leave a message on your machine at home? ☐ Yes ☐ No
Leave a message at your place of employment? ☐ Yes ☐ No
Discuss Medical Condition with any member of your household: ☐ Yes ☐ No
If Yes, whom: ______________________________ Relationship: ____________________

REFERRED BY: ☐ Physician ☐ FRIEND ☐ INTERNET ☐ OTHER ____________________
PRIMARY CARE PHYSICIAN ____________________ PHONE ____________________
ADDRESS ____
EMERGENCY CONTACT ____________________ RELATIONSHIP ____________________
PHONE ____

Patient Responsibility: Patients are responsible for all charges resulting from treatment provided.

Cosmetic services are not billable to insurance. Primary responsibility for the account is yours.

WORKERS COMPENSATION AND OTHER PERSONAL INJURY TESTIMONY IN COURT: In order to provide the best possible service, care and availability to all of our patients, it is our policy not to testify in court, depositions, arbitrations, etc. relating to Worker's Compensation and other personal injury action.

I understand my patient responsibility and hereby agree to pay the full and entire amount for services rendered whether or not covered by or paid for by by insurance. And, I will pay for those services at the time they are rendered.

____________________ ____________________ ____________

Patient Name **Patient Signature** **Date**