

**Rheumatology and Dermatology Associates
Patient Registration Sheet**

Patient Information

Legal Name: (First, Middle, Last)			Preferred Name:		
Address:		City:		State:	Zip:
Phone: ()	Cell: ()	Email Address:			
Date of Birth: / /	Social Security Number: - -	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	

Employment/School Information

Employed: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Employer/School:	Position:
Student: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		
Employer/School Address:	City:	State:
	Zip:	Phone: ()

Emergency Information

Person to Contact in Case of Emergency:			Relationship to Patient:		
Address:		City:	State:	Zip:	Phone: ()

Responsible Party for Minors

If Patient is a Minor, Responsible Party Name:			Relationship to Patient:		
Address:		City:	State:	Zip:	Phone: ()

How did you hear about us?

Primary Physician's Name & Address:

Referring Physician's Name & Address:

Primary Insurance

Policy Holder's Name: (First, Middle, Last)	Patient's Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other		Policy Holder's DOB: / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
Policy Holder's Address:	City:	State:	Zip:	Home Phone: ()
Work Phone: ()	Employer Name	Policy Holder's SS# - -	Individual ID Number:	Group Number:
Insurance Company Name & Address:				

Secondary Insurance

Policy Holder's Name: (First, Middle, Last)	Patient's Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Step Child <input type="checkbox"/> Other		Policy Holder's DOB: / /	<input type="checkbox"/> Male <input type="checkbox"/> Female
Policy Holder's Address:	City:	State:	Zip:	Home Phone: ()
Work Phone: ()	Employer Name	Policy Holder's SS# - -	Individual ID Number:	Group Number:
Insurance Company Name & Address:				

Payment Policy:

Payment is expected when services are rendered. All bills are ultimately the responsibility of the patient or guardian and not the insurance company. Any delinquent charges or returned checks may be turned over to a collection agency and a \$25.00 charge imposed. I authorize the release of medical information necessary to process insurance claims. I authorize payment of medical benefits to the physician for services rendered.

Responsible Party Signature:	Date:
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