

## PATIENT REGISTRATION FORM

3286 North side Parkway NW, Suite 130 Atlanta, GA 30327

### Patient Information:

Patient Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F (Circle one) Married/Single/Divorced/Widow

Address: \_\_\_\_\_

Race: \_\_\_\_\_ Religion: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Would you be interested in having communications sent to you via your e-mail address? (Examples: appointment Reminders, administrative updates and health bulletins) Yes No

### Other Information:

Primary Care Physician: \_\_\_\_\_

How did you hear about our Practice? \_\_\_\_\_

### Preferred Pharmacy:

Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_

Pharmacy Phone: (\_\_\_\_) \_\_\_\_\_ Pharmacy Fax: (\_\_\_\_) \_\_\_\_\_

### Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### Emergency Contact:

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Relationship: \_\_\_\_\_

### INSURANCE INFORMATION

Insurance Company: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Address: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Effective Date: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Copy Amount \$ \_\_\_\_\_ Sex: M / F

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Peachtree Dermatology Associates, PC. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Patient / Guarantor Signature \* \_\_\_\_\_ Date \_\_\_\_\_

\*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.