PEACHTREE DERMATOLOGY ASSOCIATES
Serving Atlanta Since 1957

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: _____/_____/_____
Copay 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.**