Lexington Waltham Dermatology

REGISTRATION FORM

Date:_____ (Please Print)

PATIENT INFORMATION

Patient's last name:	First:	Middle initial:	Nickname (if applicable):
Street address:	City:	State:	Zip code:
Home phone: ( )	Mobile / Cell phone: ( )	Email Address:	Gender: ❑ Male ❑ Female
Date of birth:	Age:	Name of Spouse:	Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Wid
Employer:	Employer Address:	Employer Phone no:	Referred By:
Primary Care Doctor:	Street Address:		
City:	State:	Zip code:	PCP phone no.:

Chief reason for today's visit:

_____

List any allergies you have:

_____

List any medications you are taking:

_____

List any other conditions we should know about:

_____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Name of **Primary** Insurance:	Subscribers Name:	Subscribers DOB:	Subscribers gender: ❑ Male ❑ Female
Patient's relationship to subscriber: ❑ Self	❑ Spouse	❑ Child	❑ Other
Insurance Policy ID #:	Insurance Group # (if applicable):	Co-payment: $	
Name of **Secondary** Insurance:	Subscriber's Name:	Subscribers DOB:	Subscribers gender: ❑ Male ❑ Female
Patient's relationship to subscriber: ❑ Self	❑ Spouse	❑ Child	❑ Other
Insurance Policy ID #:	Insurance Group # (if applicable):	Co-payment: $	

CONSENT / RELEASE

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits.

Assignment of Benefits

I authorize the payment of medical benefits to myself or the names provided for professional services rendered.

Release of Information:

I authorize the release of any medical information necessary to process this claim.

Signed: _____ Date: _____