**DERMATOLOGY-CHICAGO SC PATIENT REGISTRATION FORM**

FIRST MI LAST Click or tap here to enter text.

ADDRESS Click or tap here to enter text.

CITYClick or tap here to enter text.ST ZIPClick or tap here to enter text.

CELL HOME HOME

DATE OF BIRTH GENDER MARITAL STATUS Click or tap here to enter text.

EMAIL Click or tap here to enter text.

EMPLOYER Click or tap here to enter text.PRIMARY INSURANCE Click or tap here to enter text.

INSURANCE ADDRESS Click or tap here to enter text.

CITY STATE ZIP Click or tap here to enter text.

ID # Click or tap here to enter text.GROUP # COPAY $

NAME OF INSURED Click or tap here to enter text.RELATIONSHIP Click or tap here to enter text.SECONDARY INSURANCE ADDRESS Click or tap here to enter text.

CITY Click or tap here to enter text. STATE ZIP

ID #Click or tap here to enter text. GROUP #Click or tap here to enter text.

NAME OF INSURED RELATIONSHIP

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE OR MEDICARE BENEFITS AND REQUEST THAT THE PAYMENTS BE MADE TO DERMATOLOGY CHICAGO.

SIGNATURE Click or tap here to enter text.

DATE Click or tap here to enter text.