UNIQUE
Dermatology & Wellness Center
WHERE BEAUTY & HEALTH MEET

PATIENT REGISTRATION FORM

PATIENT INFORMATION (Please Print)

Name:_____**Today's Date:**___/__/__

Last First MI

Preferred Name:_____**Drivers License #:**_____

Date of Birth:_____**Social Security #:**_____
Gender: Male or Female

Marital Status: Single / Married / Divorced / Separated / Widow

Address:_____

Street City
State Zip Code

Home Phone:(_____)_____ **Cell Phone:**(____)_____**Work Phone: (**)_____

Preferred Method of Contact (Please circle one): Home Phone Cell Phone Work Phone Email

Is it OK to leave a detailed message on your voice mail? Yes or No

Personal Email Address: _____

☐ ***Please add my email address to your mailing list to receive e-mail updates/ specials***

Preferred Language (Please circle one): English Spanish Other:_____

Race (Please circle one): American Indian/Alaskan Native Asian Black/ African American

Native Hawaiian/Pacific Islander White/ Caucasian Unknown

Ethnicity (Please circle one): Hispanic of Latino Not Hispanic or Latino Decline to specify

PATIENT EMPLOYMENT INFORMATION

Employment Status: Employed Student Self-employed Retired

Employer's Name: _____**Occupation:** _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____**Relationship:** _____

Phone #1: (_____)_____ Phone#2: (_____)_____

Would you like your medical information released to any family member? Yes No

If yes, whom?_____Relationship to you:_____Phone#:_____

HOW DID YOU HEAR ABOUT US?

Physician / Family / Friend / Yellow Pages/ Insurance Carrier/ Internet / Newspaper Ad/ Exterior Signage Other: _____

PRIMARY CARE PHYSICIAN

Name: _____Practice Name: _____

INSURANCE INFORMATION : ***(Please present your current insurance card at time of check in).***

Primary Insurance**:_____** **Secondary** Insurance:_____

Policy ID#:_____ **Policy ID#:_____**

Group #:_____ **Group #:_____**

Insurance Phone #:_____ **Insurance Phone #:_____**

Policy Holder (if not patient):_____ **Policy Holder (if not patient):_____**

Policy Holder SSN:_____ **Policy Holder SSN:_____**

Policy Holder Date of Birth:_____ **Policy Holder Date of Birth:_____**

I understand that I am responsible for all fees regardless of insurance coverage, and that charges are due at time of service unless other arrangements have been made in advance of treatment. If Unique Dermatology & Wellness Center does bill my insurance, I authorize them to release any or all of my medical records to my insurance companies for assigned payment of medical benefits. I also understand that I will be billed separately by the laboratory for any lab tests that are sent out for testing. Consent is hereby given to the treating physician to administer treatment and to perform such medical and/or surgical procedures that are deemed necessary for treatment.

Patient (Print Name):_____
Date:_____

Patient (Signature):_____