HOLLAND Dermatology

Barbara S. Drozdowski, MD FAAD

Patient Registration Form

Patient Name: _____ Birth Date: ____/____/____
First Middle Initial Last

☐Male ☐ Female

Social Security # _____-_____-_____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Street Address: _____City:_____State:_____Zip:_____

Primary Phone Number: _____ ☐ Cell ☐ Landline

Secondary Phone Number:_____ ☐ Cell ☐ Landline

Email address: _____

Emergency Contact Name: _____Phone Number: _____

- ☐ **I DO** authorize the physicians and employees of *Holland Dermatology* to **leave information** regarding appointment changes, laboratory results, biopsy results, or other diagnostic tests at the contact numbers/ voicemail listed above.
- ☐ **I DO NOT** authorize the physicians and employees of *Holland Dermatology* to leave any information regarding laboratory results, biopsy results, or other diagnostic tests on my answering machine/voicemail.

Primary Insurance:_____ Policy #:_____ Group #:_____

Subscriber Name/Date of Birth:_____

Secondary Insurance:_____ Policy #:_____ Group#:_____

Subscriber Name/Date of Birth:_____

OPTIONAL - Please circle whichever option applies for EACH of the *questions* below:

Race: Asian American Indian or Alaska Native African American
Native Hawaiian Other Pacific Islander White Do Not Wish to Report

Ethnicity: Hispanic or Latino Not Hispanic or Latino Do Not Wish to Report

Primary Language: _____

Please be aware that biopsies performed in this facility will be subject to Pathology charges. If you have concerns or questions related to this matter, please be sure to address them with the nurse or doctor, prior to the completion of a biopsy procedure.*

PLEASE NOTE: As a *courtesy*, **ALL** of our patients are notified of upcoming appointments in our office via automated phone call, text message, and/or email.

*By signing below you are stating that you are aware of the Notice of Privacy Practices from Holland Dermatology and understand how my medical information may be used, disclosed and protected**

Signature of Patient:_____Date:_____
(Legal Guardian if Patient is a Minor)

(Updated 04-02-2019)