INTEGRATED
DERMATOLOGY
OF WATERBURY

REGISTRATION INFORMATION

PATIENT INFORMATION				DATE:			
LAST NAME	FIRST NAME		MI	BIRTHDATE	SOCIAL SECURITY #		
HOME ADDRESS		CITY	STATE	ZIP		SEX:	☐ MALE ☐ FEMALE
SPOUSE'S NAME		HOME #		WORK #			
EMAIL ADDRESS		MOBILE #		MARTIAL STATUS: ☐ MARRIED ☐ SINGLE			
RESPONSIBLE PARTY INFORMATION (If other than self)				☐ DIVORCED ☐ SEPERATED ☐ WIDOWED			

RESPONSIBLE PARTY INFORMATION					
LAST NAME	FIRST NAME		MI	HOME #	
ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #	
EMPLOYER		OCCUPATION		WORK #	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY ☐ SPOUSE ☐ SON ☐ DAUGHTER	

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT	OCCUPATION	EMPLOYMENT OR STUDENT STATUS:
PATIENT'S EMPLOYER OR SCHOOL ADDRESS		☐ FULL-TIME ☐ PART-TIME ☐ SELF EMPLOYED
CITY	STATE ZIP	☐ NOT EMPLOYED ☐ ACTIVE MILITARY ☐ RETIRED

EMERGENCY INFORMATION

NAME	RELATIONSHIP	HOME #	
ADDRESS	CITY	STATE	ZIP	WORK #

INSURANCE INFORMATION ☐ PPO ☐ POS ☐ MEDICARE ☐ HMO CO-PAY $

PRIMARY INSURANCE	SOCIAL SECURITY #	CARDHOLDER		DATE OF BIRTH
GROUP NUMBER		IDENTIFICATION NUMBER		EFFECTIVE DATE
ADDRESS	CITY	STATE	ZIP	PHONE NUMBER
SECONDARY INSURANCE		CARDHOLDER		DATE OF BIRTH
GROUP NUMBER		IDENTIFICATION NUMBER		EFFECTIVE DATE
ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

TRICARE INSURANCE INFORMATION-To be completed by TriCare patients only.

SPONSORS NAME	DATE OF BIRTH	SOCIAL SECURITY #

PHARMACY INFORMATION-Must provide complete address information to ensure your prescriptions are sent to the correct pharmacy.

PHARMACY NAME	PHARMACY PHONE NUMBER		
ADDRESS	CITY	STATE	ZIP