Patient Registration Form

Please fill out this form and bring it with you to the SkinPros office.

SKINPROS
Your Skin. Our Expertise.

Name _____ Today's Date _____
LAST FIRST M.I.

Mailing Address _____ City _____ State _____ Zip _____
NUMBER, STREET, APARTMENT NUMBER

Age _____ Primary Language _____ Race _____ ☐ DECLINE TO ANSWER

Home Phone (___) _____ Work Phone (___) _____ Cell Phone (___) _____

Date of Birth / / SS # _____ Marital Status _____ Gender _____

Email _____ Ethnicity: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ DECLINE TO ANSWER

Would you like to participate in our patient portal to access your records and communicate with the provider? ☐ Y ☐ N

Employer _____ ☐ RETIRED ☐ FULL-TIME STUDENT ☐ PART-TIME STUDENT

Spouse's Name _____ Spouse's Employer _____ Work Phone (___) _____

Person to notify in case of emergency _____ Phone _____
(PLEASE LIST A PERSON *NOT* LIVING IN YOUR HOME)

Referring Doctor _____

Primary Doctor _____

Pharmacy Name/Address _____

May we leave a message on your home answering machine? ☐ Y ☐ N
May we leave a message for you at work to call us? ☐ Y ☐ N
May we discuss your medical condition with another person? ☐ Y ☐ N

If yes, whom? _____ Relationship _____

How did you hear about our practice? _____

Insurance Provider Name _____ Policy # _____ Group # _____

Policy Holder (if different from patient or responsible party) _____

Policy Holder's Date of Birth / / SS # _____

Employer of Policy Holder _____ Work Phone (___) _____

Patient's Relationship to Policy Holder _____

If patient is a minor, please enter responsible party information.
NOTE: We do not bill absent parents. The adult presenting the minor for care is the responsible party.

Name _____ Today's date _____
LAST FIRST M.I.

Mailing Address _____ City _____ State _____ Zip _____
NUMBER, STREET, APARTMENT NUMBER

Age _____ Home Phone (___) _____ Work Phone (___) _____ Cell Phone (___) _____