P: 505.225.2500 | **F:** 505.225.2025
610 Broadway Blvd. N.E. , Albuquerque, NM 87102
dermatologynm.com

Patient Registration

GENERAL INFORMATION

Patient's Legal Name *(as it appear as on Driver's Licence or Photo ID)*

Last Name: ______________ First Name: ______________ Middle initial: ______

Social Security Number: ______________ Patient Date of Birth (MM/DD/YYYY): ______________

Birth Sex: ______________ Preferred Language: ______________

Race: ______________ Ethnic Group: ______________

Marital Status: ______________ Drivers license number: ______________

CONTACT INFORMATION

Preferred Contact method: ❑ Phone ❑ Letter

Emergency Contact Name: ______________ Phone: ______________

Spouse Full Name: ______________ Phone: ______________

Caretaker Full Name: ______________ Phone: ______________

Patient Phone: ______________ (Home) ______________ (Work) ______________ (Mobile)

Preferred Phone: ❑ Home ❑ Work ❑ Mobile Is it OK to leave a detailed message? ❑ Yes ❑ No

Email Address: ______________

Would you like to opt in to email notifications? ❑ Yes ❑ No

MAILING ADDRESS

Street: ______________

City: ______________ State: ______________ Zip: ______________

EMPLOYER INFORMATION

Employer's Name: ______________________________

Employer Phone: ______________________ Occupation: ______________________

GUARANTOR/RESPONSIBLE PARTY INFORMATION

Patient's Relationship to Guarantor: ❑ Self ❑ Spouse ❑ Child ❑ Other ❑ Employee

Guarantor Last Name: ______________________ Guarantor First Name: ______________________

Guarantor Date of Birth: ______________________ Guarantor SSN: ______________________

❑ Guarantor Address is same as patient

❑ Guarantor Address if different:

Street: ______________________________

City: ______________________ State: ____________ Zip: ____________

Guarantor Phone: ______________________ Guarantor Email: ______________________

AUTHORIZATION

Authorization to Disclose Protected Health Information–I authorize the individual below access to my Protected Health Information.

Last Name: ______________________ First Name: ______________________

Home Phone: ______________________ Mobile Phone: ______________________

Relationship to the patient: ❑ Spouse ❑ Parent ❑ Child ❑ Friend ❑ Other

INSURANCE INFORMATION

PRIMARY Insurance Company: ______________________________

Plan Name: ______________________ Policy Number: ______________________

Group Number: ______________________ Policy Type: ______________________

Last Name on Insurance Card: ______________________________

First Name of Insurance Card: ______________________ Middle Initial: ________

Patient's Relationship to Policy Holder: ______________________________

Specialist Co-Pay amount: ______________________
Please call insurance if unknown

Deductible: ______________________
Please call insurance if unknown

SECONDARY INSURANCE INFORMATION

SECONDARY Insurance Company: ______________________________

Plan Name: ______________________ Policy Number: ______________________

Group Number: ______________________ Policy Type: ______________________

Last Name on Insurance Card: ______________________________

First Name of Insurance Card: ______________________ Middle Initial: ________

Patient's Relationship to Policy Holder: ______________________________

Specialist Co-Pay amount: ______________________
Please call insurance if unknown

Deductible: ______________________
Please call insurance if unknown

PHARMACY INFORMATION

Preferred Pharmacy Name *(list address or cross roads)*: ______________________________

____

Pharmacy Phone: ______________________________

PRIMARY CARE PHYSCIAN INFORMATION

Primary Care Physician(PCP): ______________________________

PCP Phone: ______________________________

REFERRED TO CLINIC BY:

Dr. ______________________________ Phone Number: ______________

❑ Family/friend ❑ Insurance ❑ Web search ❑ Print ad ❑ Other ad

I acknowledge this is information is accurate and complete and understand this information will be part of my medical record.

______________________________ ______________

Signature of patient or authorized representative Date

Below: For Office Staff Only

❑ New or ❑ Established Patient

Portal setting enabled: ❑ Yes ❑ No

Patient representative account enabled: ❑ Yes ❑ No ❑ N/A

Username: ______________________________