DERMATOLOGY
OF NEW MEXICO

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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: _____

Last 4 of 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 ❑ Email

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: _____

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: _____ Deductible: _____

Please call insurance if unknown *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: _____ Deductible: _____

Please call insurance if unknown *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