PATIENT REGISTRATION

deschutes dermatology
MEDICAL AESTHETIC

PATIENT INFORMATION Date Completed _____/_____/_____

Full name _____ SS# _____
Last First MI

Address _____ Apt # _____ Gender ☐ M ☐ F

City/State _____Zip_____ Birth date _____Age_____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Daytime Phone _____ OK to leave voice message? **PLEASE INITIAL** YES_____ NO_____

Cell Phone _____ OK to leave text/voice message? **PLEASE INITIAL** YES_____ NO_____

Work Phone _____ OK to leave voice message? **PLEASE INITIAL** YES_____ NO_____

Email Address _____ ☐ Opt-out for Cosmetic Specials
Email address used for appointment reminders / Patient Contact and Information / Cosmetic specials

Pharmacy _____ Primary Care Physician _____

Employer _____ Occupation _____

SPOUSE or **PARENT** (if patient is a minor)
Full Name _____ Birth date _____
Last First MI
SS# _____ Employer _____ Work Phone _____

Address ☐ Same as above _____City/State_____ Zip _____

I give permission to discuss my medical condition with this person ☐ Yes ☐ No

INSURANCE INFORMATION

Please present your insurance card to the receptionist when you arrive at the clinic. Insurance will only be billed if a card is presented.
IN ADDITION TO PROVIDING YOUR INSURANCE CARD, COMPLETE INFORMATION BELOW.

INSURED/SUBSCRIBER _____
Last First MI

WHO MAY WE CONTACT IF WE CAN'T REACH YOU:

Full Name _____ Daytime Phone _____
Last First MI
Relationship to patient _____
Address _____ City/State _____ Zip _____

I give permission to discuss my medical condition with this person ☐ Yes ☐ No

- I have read and understand the Financial Policy. I have been provided a copy for my personal records.
- I give permission to Deschutes Dermatology Center to bill my insurance.
- I authorize the taking of photographs to document my medical condition.
- I authorize Deschutes Dermatology to obtain information on my prescription(s) from SureScripts to conduct electronic prescribing.

SIGNATURE _____ DATE_____

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