ATLANTIC DERMATOLOGIC ASSOCIATES, LLP
PATIENT REGISTRATION FORM

□ BELLM □ LYN
□ HB □ VS
□ KIM

PLEASE PRINT CLEARLY

Name_____ **Age**_____ **DOB**_____ **Sex**_____

Street Address & APT #_____

City _____ **State**_____ **Zip Code** _____ **SSN#**_____

Home Phone#( )_____ **Cell( )**_____ **Work( )**_____

Which Number is Preferred? □ Home □ Cell □ Work **Marital Status: □ M □ S □ D □ W**
Reminder Call Preference: □ Call □ Text □ Email

Preferred Language_____ **Race: □ American Indian/Alaskan Native □ Asian □ Black □ Native Hawaiian/Pacific Islander □ White □ Decline to Answer**

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Decline to Answer

Occupation_____ **Employer**_____

Employer's Address_____

Pharmacy Name_____ **Phone #**_____

Referred By: □ Doctor □ Friend □ Relative □ Insurance Plan □ Advertisement □ Web Site □ Web Search
Primary or Referring Physician:
Address &
Name_____ **Phone #** _____

Do we have your permission to:

Leave a message on your answering machine? □ Yes □ No
Leave a message on voice mail at work? □ Yes □ No
Contact you by email? □ Yes □ No Email Address_____
Discuss your medical condition with a member of your household? □ Y □ N If yes,

Name_____ **Relationship**_____

Phone Number_____

EMERGENCY CONTACT INFORMATION or PARENT/GUARDIAN INFO

Name_____ **Relationship** _____

Address_____

Home/Work Phone_____ **Cell Phone**_____

Signature_____ ***Date***_____

PARENT/GUARDIAN AUTHORIZATION TREATMENT OF MINOR

Since my minor child_____**, will be coming to the office for regular treatment of his/her dermatologic condition unaccompanied by me, I authorize Atlantic Dermatologic Associates, LLP, to examine, evaluate, and render treatment for my child. I understand that no surgical procedure will be rendered without further discussion and informed consent.**

Signed _____ **Date**_____

Print Name _____

Witness Signature _____ **Date**_____

Print Name _____