Dermatology Medical Group of San Francisco, Inc.

New Patient Registration & Medical History

DATE: _____

PATIENT INFORMATION

PATIENT NAME_____
LAST FIRST MIDDLE INITIAL

ADDRESS _____
STREET CITY STATE ZIP

PHONE (CHECK ☑ PREFERRED CONTACT NUMBER):
❑HOME _____ **❑CELL** _____ **❑WORK**_____

E-MAIL _____ *Do you authorize us to send information to this email address?*
❑YES ❑NO

BIRTHDATE_____ **SOCIAL SECURITY #**_____

GENDER ❑ MALE ❑ FEMALE **MARITAL STATUS** ❑ SINGLE ❑MARRIED ❑DIVORCED ❑WIDOWED

OCCUPATION_____

EMPLOYER _____ **ADDRESS** _____

NAME OF SPOUSE/PARTNER_____
LAST FIRST MIDDLE INITIAL

ADDRESS _____
STREET CITY STATE ZIP

EMPLOYER _____ **WORK PHONE** _____

EMERGENCY CONTACT

NAME: _____ **PHONE:** (____) _____-_____ **RELATIONSHIP:** _____

PREFERRED CONTACT NUMBER *Please indicate which phone number we are authorized to use if we need to report lab test results.*

IF YES, PLEASE PROVIDE YOUR PREFERRED NUMBER: _____

MAY WE LEAVE A MESSAGE? ❑ YES ❑ NO

OTHER HEALTHCARE PROVIDERS

PRIMARY CARE PHYSICIAN_____
NAME PHONE NUMBER

PCP ADDRESS _____
STREET SUITE CITY STATE ZIP

REFERRED BY:
❑PHYSICIAN ❑ PATIENT ❑WEBSITE ❑OTHER

_____
REFERRING NAME PHONE NUMBER

REASON FOR TODAYS VISIT_____

HOW LONG HAVE YOU HAD IT?_____

HAVE YOU BEEN TREATED FOR THIS CONDITION?_____

INSURANCE INFORMATION

PRIMARY INSURANCE

NAME OF INSURED _____ __

RELATIONSHIP TO PATIENT _____

INSURED'S BIRTH DATE _____

SOCIAL SECURITY # _____ - _____ - _____

EMPLOYER _____

INSURANCE CO. _____

EMPLOYEE I.D./CERT.# _____

GROUP # _____

SECONDARY INSURANCE

NAME OF INSURED _____

RELATIONSHIP TO PATIENT _____

INSURED'S BIRTH DATE _____

SOCIAL SECURITY # _____ - _____ - _____

EMPLOYER _____

INSURANCE CO. _____

EMPLOYEE I.D./CERT.# _____

GROUP # _____

FINANCIAL POLICY

I, the undersigned, understand that I am receiving services from an out-of-network provider. This means that DMGSF does not participate in my insurance plan. Since DMGSF does not participate with my insurance plan, **payment in full is due at the time services are rendered.**

As a courtesy, Dermatology Medical Group of San Francisco will submit claims to my insurance on my behalf and I understand that I am financially responsible for all charges incurred with the Dermatology Medical Group of San Francisco, Inc.

_____

Signature of Responsible Party

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

***Please see clipboard**

Receipt of Notice of Privacy Practices
Dermatology Medical Group of San Francisco, Inc.

I am a patient of _____. I hereby acknowledge receipt of Dermatology Medical Group of San Francisco's Notice of Privacy Practices.

Name: (please print):_____ Signature:_____

Or

I am a parent or legal guardian of _____(patient name). I hereby acknowledge receipt of Dermatology Medical Group of San Francisco' s Notice of Privacy Practices with respect to the patient.

Name (please print):_____

Relationship to Patient:_____

Signature:_____