Name:
DOB:
Chart:
Age:
Date:

Pinehurst Dermatology Patient Registration

PATIENT DATA

Name (Last, First, MI): _____
Mailing Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Date of Birth: _____ Age: _____ SSN: _____ Sex: _____
☐ Single ☐ Married ☐ Divorced ☐ Widow
Primary Care Physician: _____ Name of Previous Dermatologist: _____
Race: ☐ Caucasian ☐ America Indian ☐ Asian ☐ African American ☐ Native Hawaiian ☐ Type-Unknown
☐ I prefer not to answer this question
Ethnicity: ☐ Hispanic Origin ☐ Non-Hispanic Origin ☐ Type Unknown ☐ I prefer not to answer this question
Preferred Language: ☐ English ☐ Spanish ☐ Hindi ☐ Chinese ☐ Korean ☐ Italian ☐ Japanese
☐ Vietnamese ☐ I prefer not to answer this question
Smoking Status: ☐ Current every day smoker Packs per day: _____
☐ Current some day smoker Packs per day: _____
☐ Smoker, current status unknown ☐ Never smoker ☐ Former smoker ☐ Unknown if ever smoked
If you have ever smoked: Year started: _____ Year stopped: _____

Please provide your email address so we may send you a link to access your patient portal. By providing your email address you are giving Pinehurst Dermatology permission to send you an invitation to view your Pinehurst Dermatology related personal health information. This is not used for any other purpose and is not given to any third party.

Email: _____
Do you consent to receive medical results by email? ☐ Yes ☐ No

RESPONSIBLE PARTY/POLICY HOLDER DATA

Name (Last, First, MI): _____
Mailing Address (if different than patient): _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
SSN: _____ Employer: _____ Relationship to patient: _____
Primary Insurance Company: _____
Policy Number: _____ Policy Holder: _____
Secondary Insurance Company: _____
Policy Number: _____ Policy Holder: _____
Emergency Contact: _____ Relationship to patient: _____
Phone Number: _____

REFERRAL DATA

☐ Referring Physician: _____ ☐ Friend/Relative: _____
☐ Insurance Plan Directory: _____ ☐ Yellow Pages: _____
☐ Other (specify): _____

CONSENT

May we leave a message on your answering machine or voicemail? ☐ Yes ☐ No
May we discuss your medical condition with any member of your family? ☐ Yes ☐ No
If yes, whom? _____ Relationship: _____
Signature: _____ Date: _____

STATEMENT OF FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFIT

I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of Pinehurst Dermatology, PA. I assign and authorize payments to Pinehurst Dermatology, PA. I understand my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand I am responsible for fees not paid in full, co-payments, and policy deductibles and co-insurance except where my liability is limited by contract or state or federal law. I authorize Pinehurst Dermatology, PA to release such medical information necessary to process my insurance claim, if any. This authorization shall be valid until rescinded in writing or replaced by one of a later date.

Signature of Patient or Legal Guardian: _____ Date: _____