

PLACER DERMATOLOGY

& Skin Care Center

9285 Sierra College Blvd., Roseville, CA 95661

Phone (916) 784-3376 Fax (916) 784-9500

Please fax or send completed form prior to your appointment.

Patient Registration Information

Patient Name: _____ Today's Date: _____
Last First M.I.

Date of Birth: ___/___/___ Age: _____ Gender: Male Female

Marital Status: Married Single Divorced Widowed

SSN: _____ Occupation: _____ Employer: _____

Home Address: _____
City State Zip

Home Phone: () _____ Work Phone: () _____

Cell Phone: () _____ e-mail: _____

May we leave personal medical information on your:

Home answering machine? Yes No Cell Phone? Yes No Work Phone? Yes No

Do you give our office permission to discuss your medical information with family members? Yes No

Name: _____ Phone: () _____

Relationship to patient: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)

Name: _____ Date of Birth: ___/___/___
Last First M.I.

Relationship to patient: _____ Address: **Same as above**

or _____
City State Zip

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

In case of emergency, whom should we notify?

Same as above

Or, Name: _____
City State Zip

Relationship to patient: _____ Phone: () _____

PRIMARY INSURANCE

Name of Insurance Company: _____

Address: _____
City State Zip

Name of Policy Holder (insured): _____ Date of Birth: ___/___/___

Policy Number: _____ Group Name or Number: _____

Policy Type: HMO PPO Other _____

Relationship to patient: _____

SECONDARY INSURANCE

Name of Insurance Company: _____

Address: _____
City State Zip

Name of Policy Holder (insured): _____ Date of Birth: ___/___/___

Policy Number: _____ Group Name or Number: _____

Policy Type: HMO PPO Other _____

Relationship to patient: _____

REFERRING PHYSICIAN

Name: _____ Phone Number: () _____
Last First M.I.

PRIMARY CARE PHYSICIAN Same as above

Name: _____ Phone Number: () _____
Last First M.I.

PHARMACY OF CHOICE

Name: _____ Phone Number: () _____

Address: _____
City State Zip

HOW DID YOU LEARN ABOUT PLACER DERMATOLOGY? Please specify. Thank you.

AUTHORIZATIONS

- I authorize the release of medical information to my primary care or referring physician, to any consultants as needed, and as necessary to process insurance claims and prescriptions.
- I have received and/or reviewed a copy of the Notice of Privacy Practices from Placer Dermatology.
- I authorize Placer Dermatology to take digital photographs for my medical record if medically necessary.
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Signature: _____ **Date:** _____

Our office will file insurance for all reimbursable service, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts at the time of your visit.

Please present your insurance card(s) and your photo ID to the receptionist at check in. Thank you.