Registration

How did you hear about us?
- ❑Friend/Neighbor
- ❑Physician
- ❑Phone Book
- ❑Advertisement
- ❑Other_____

First, Middle, Last Name _____ Preferred Name _____ Maiden Name _____

Address _____ City, State, Zip Code _____ Email Address _____

Date of Birth _____ Social Security Number _____ Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Gender: ❑ Male ❑ Female Employment Status: ❑ Employed ❑ Student ❑ Unemployed ❑ Retired

Language Preference: ❑English ❑Other_____ Ethnicity: _____

❑_____ ❑_____ ❑_____

Home Phone Cell Phone/Cell Provider Other Phone Number

Is your illness or injury related to an accident? ❑ Yes ❑ No

Emergency Contact Information:

Name _____ Phone Number _____ Relationship to Patient _____

If patient is a minor please list person responsible for payment:

Name _____ Address _____ Phone Number _____

Name of Primary Care Doctor:_____City/State/Phone Number _____

I consent for my medical records to be released to: ❑ My Primary Care Provider ❑ Any Doctors involved with my care.

❑ Spouse:_____ ❑ Other:_____Relationship:_____

❑ I *do not* consent to the release of any medical records without my expressed written consent to that provider.

In order to facilitate prompt notification about biopsy or lab results we need your permission to leave a detailed message on your home, cell or other phone number provided. This message will include your name, biopsy date and location, the results and the treatment needed.

I consent for Paragon Dermatology to leave a detailed message at: (Check all that apply)

❑ Home ❑ Cell ❑ Other# listed number ❑ On the answering machine ❑ With anyone who answers the phone.

Please **do not** leave a message with _____.

With my signature below, I certify that all of the above information is true to the best of my knowledge. I understand that this information will be kept in my medical records and the above parameters will be abided by until revoked by me in writing. I further understand that it is my responsibility to notify Paragon Dermatology if any of the above information or preferences change.

_____ _____

Patient's Signature/Parent's if patient is a minor Date