WAKE DERMATOLOGY ASSOCIATES PATIENT REGISTRATION FORM

Full Name:_____**Suffix:** _____

Birthdate:_____**Gender:** M / F **Marital Status:** S M D W **Soc. Sec. #**_____

Address: _____**Apt/Unit:**_____

City/State/Zip: _____

E-Mail Address for Patient Portal:_____

Preferred Phone (Is this a mobile? Y / N **):** [_____]-[_____] **Other Phone:** [____]-[_____]

PARENT/GUARDIAN FOR MINORS:

Full Name:_____**Birthdate:**_____

Relationship to Patient:_____**Soc. Sec. #**_____

Address (if different):_____**Phone:**_____

THE POLICYHOLDER OF MY INSURANCE IS:

Primary: SELF SPOUSE MOTHER FATHER [Name/DOB:_____**]**

Secondary: SELF SPOUSE MOTHER FATHER [Name/DOB:_____**]**

Optional Federal Mandate Demographic Information. Please check one of the following:

Ethnicity:	o Hispanic or Latino	o Not Hispanic or Latino	o Declined to specify
Race:	o American Indian	o Alaska Native	o Asian
	o Black or African American	o Native Hawaiian	o Other Pacific Islander
	o White or Caucasian	o More than one race	o Declined to specify
Preferred Language:	o English	o Other (specify):	o Declined to specify

CONSENT AND ACKNOWLEDGEMENTS

- I hereby assign my insurance benefits to be paid directly to Wake Dermatology Associates. This authorization shall be valid until rescinded in writing or replaced by one at a later date. I authorize the physician to release any medical information required to process my claims.
- I understand that I am financially responsible for all non-covered services, co-payments, co-insurance and deductibles. I authorize and give consent for my provider to bill me directly for recommended services performed that are not covered under the terms of my health plan.
- I authorize my provider's office to contact me by preferred phone number with information about my care, appointment reminders or other matters related to my account.
- I authorize this practice to obtain my medication history.
- I acknowledge that a copy of the Notice of Privacy Practices has been made available to me.

_____ _____

Signature of Patient/Responsible Party or Parent/Legal Guardian **Date**