Park Avenue Dermatology
Patient Registration Form

□ **New Patient** □ **Name Change** □ **Address Change** □ **Insurance Change**

IMPORTANT: Please present ALL Insurance cards to the receptionist. If patient is a minor and you are not the legal guardian, speak with the receptionist immediately

Patient Information: **Please Complete All Fields Using Legal Names of the Parties Involved.**

Name: First_____**MI**____ **Last** _____
Date of Birth:_____ **Age**:___ **Occupation:** _____**Sex**: □ **Male** □ **Female**
Social Security #: ___- ___ - ___

Mailing Address: _____ **Apt #:** ___ **City:**_____ **State:**____ **Zip:**_____
Cell Phone: _____ **Work**:_____ **Home:** _____
E-mail: _____

Marital Status (Please Circle): Single Married Separated Divorced Widowed

Pharmacy Name: _____ Address/Town/Phone #: _____

Referring Physician or Primary Doctor Name: _____
Address/Town: _____ Phone #: _____

How did you hear about us (Please Circle): Internet/Website | Advertising | Ins.Co. | Friend/Relative (Name_____)

Insurance Information:

PATIENT IS RESPONSIBLE FOR INFORMING OUR OFFICE OF PARTICIPATING LAB:_____
Primary Insurance Carrier Name: _____
Name: First_____MI___ Last_____
Date of Birth:_____ SS#: _____ - _____-_____ Relationship to the Patient:_____
Mailing Address:_____
Cell Phone: _____Home:_____Work:_____

Secondary Insurance Carrier Name: _____
Annual Deductible: **$**_____ **Co-pay: $**_____
Does this insurance require a referral? ***Yes*** ____ ***No***____ ***(Patient is responsible for referrals at the time of the visit)***

EMERGENCY Contact Person:

Name_____ **Phone #:**_____

Patient Release: Must be signed by patient if over 18 or by legal guardian of patient under 18.
I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process Insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.
I certify that I hereby authorize Ligresti Dermatology Associates, its providers and staff to provide my minor child in my absence with examinations and basic treatments for which additional consents are not required. I understand as the legal guardian of this child I am required to be physically present to consult with the provider on any procedures which required separate consent such as surgery, biopsy, or wart destructions. I understand additional written consent maybe necessary for these types of procedures and the legal guardian must be present for such consent.

Signature:_____ **Date:**_____

Would you like a complementary COSMETIC CONSULTATION during your visit today? □ ***Yes*** □ ***No***