Alaska Center for Dermatology, P. C.

3841 Piper Street | Suite T4-020 | Anchorage, AK 99508 | telephone 907.646.8500 | fax 907.646.9760

Patient Registration Form

Patient Name _____ _____ _____ Date of Birth _____/_____/_____
first middle initial last

Nickname _____SS# _____/_____/_____ Sex: ☐ M ☐ F

Email Address: _____

Mailing Address:_____ _____ _____ _____
city state zip

Which phone number would you like to designate as your **primary number**? ☐ Cell ☐ Home ☐ Work

Cell Phone	**Home Phone**	**Work Phone**
_____	_____	_____
Choose ONE of the following: ☐ Leave detailed message ☐ Leave message with call-back number only ☐ Leave no message	Choose ONE of the following: ☐ Leave detailed message ☐ Leave message with call-back number only ☐ Leave no message	Choose ONE of the following: ☐ Leave detailed message ☐ Leave message with call-back number only ☐ Leave no message

Emergency Contact Name_____

Phone(s)_____ Relationship to Patient _____

Do you authorize us to communicate with another individual, such as spouse or relative? If so, please indicate below.

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Primary Insurance	**Secondary Insurance**
Ins Co Name_____	Ins Co Name_____
Subscriber ID#_____	Subscriber ID#_____
Subscriber Name_____	Subscriber Name_____
Subscriber DOB_____ Relationship to Pt_____	Subscriber DOB_____ Relationship to Pt_____

Responsible Party for Minor *If patient is a minor, the parent accompanying them today is the Responsible Party. This information will also apply to patients who have a designated legal guardian. Responsible Party must sign Assignment and Release below.*

RP Name _____Date of Birth ____/_____/_____SS# _____/_____/_____

Mailing Address:_____ _____ _____ _____
city state zip

Assignment and Release *I authorize the release of any information to my referring physician. I authorize Alaska Center for Dermatology to furnish my information to insurance carriers upon their written request and I assign to Alaska Center for Dermatology all payments for medical services rendered.*

_____ _____

Patient Signature (RP, if Patient is a Minor) **Date**