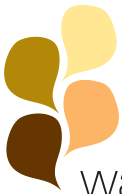

wake forest dermatology

PATIENT REGISTRATION FORM

Account #: ____________________
OFFICE USE ONLY

Patient Information

Today's Date: ____________ SS#: ______________________ Gender: ❑ M ❑ F
Last Name: ______________________ First Name: ______________________ Middle Initial: ________
Date of Birth: ______________ Age: __________ Marital Status: ❑ Single ❑ Married ❑ Divorced
Address: ____
City: ______________________________ State: ______ Zip Code: ______________
Home Phone #: ______________________ Cell Phone #: ______________________
Email address: ____

Employer: ______________________________ Work Phone#: ______________________
Employer Address: ____

Referring Doctor: ____________________ Office Phone: ____________ Office Fax: ____________
Doctor's Address: ____

Pharmacy: ______________________________ Phone #: ______________________
Pharmacy's Address: ____

Primary Insurance

Company: ______________________________ Insured's Name: ______________________
If NOT the patient, please provide the following: ______________________________
Insured's Date of Birth: ______________________ Insured's ID/SS#: ______________________
Insured's Employer: ____

Secondary Insurance

Company: ______________________________ Insured's Name: ______________________
If NOT the patient, please provide the following: ______________________________
Insured's Date of Birth: ______________________ Insured's ID/SS#: ______________________
Insured's Employer: ____

Emergency Contact Information/Designated Individuals Release

Wake Forest Dermatology may release to, or discuss my personal health information (PHI) (except regarding treatment, payment, and/or administrative operations) with, the individuals listed below, verbally or in writing. I understand that Wake Forest Dermatology will make the best efforts to verify the identity of the designated parties before disclosing PHI.

Name: ______________________ Relationship: ____________ Phone #: ____________
Name: ______________________ Relationship: ____________ Phone #: ____________
Please Identify any person(s) to whom PHI may NOT be provided:

____

I hereby authorize payment of medical benefits billed to my insurance company to be paid directly to Patricia Matheis, MD, PC, d/b/a/ Wake Forest Dermatology. I hereby agree to promptly pay for any service(s) provided to me not covered by my insurance policy. I agree to pay all copayments, coinsurance, and deductibles; and for cosmetic services at the time the service is rendered. I also agree to provide at least 2 business days notice if I need to cancel/reschedule an appointment. Wake Forest Dermatology Notice of Information Practices has been made available to me. If/when any of the above information changes, I will provide the updated information promptly. I also understand that I may change any of the Emergency Contact Information/Designated Individuals Release Information at any time, by asking for and completing a new Designated Individuals Release form. I understand that my provider and I will discuss and agree on an appropriate treatment plan, and consent to such treatment as discussed. If the patient is a minor, and presents to be evaluated and/or treated by a provider at this practice without an accompanying parent/legal guardian, I hereby give my permission to evaluate and treat the patient.

I have read and understand the above.

____ ______________________
Signature of Patient (if over 18) or Patient's Parent/Legal Guardian Date
If signed by parent/legal guardian, please print name of responsible party: ______________________

2824 Rogers Road, Ste 101 · Wake Forest NC 27587 · 919.488.0355
www.wakeforestderm.com

*Please inform the receptionist of any phone number(s) where we may not leave a message.