COAST DERMATOLOGY & SKIN CANCER CENTER
J. Gregory Neily, DO

PATIENT REGISTRATION FORM

Patient Name:_____ **Date:**_____
First Middle Last

Address:_____
Street Apt/Unit City State Zip

Date of Birth:_____ **Sex:** ☐ M ☐ F **Marital Status**: ☐ Married Single Divorced Wid ☐Sep

Social Security #: _____ **Age:**_____ **Name of Spouse**:_____

Home Phone: ( )_____ **Work Phone:** ( )_____

Cell Phone: ( )_____ **E-Mail**:_____

Ethnicity: _____ **Language:** _____ **Race:** _____

Parent/Legal Guardian Name (if patient is a Minor)_____

Employer:_____
Name Address Phone

Emergency Contact:_____
Name Relationship Phone

Primary Care Physician:_____
Name Phone

Insurance: _____
Company Address Phone

Relation to Insured (Please circle one): **SELF** **SPOUSE** **CHILD**

DOB of Insured party: _____

Secondary Insurance: _____
Company Address Phone

Relation to Insured (Please circle one): **SELF** **SPOUSE** **CHILD**

DOB of Insured party: _____

Who referred you to us? ☐ _____

Preferred Pharmacy:_____ **Phone:**_____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

I authorize <u>any</u> information to be provided to the following person(s):

_____
Name(s) (Relation – i.e. spouse, son, daughter, etc.)

_____
Signature of Patient or Personal Representative Date