

Advanced Dermatology of San Clemente, Inc.

675 Camino De Los Mares, Suite 400
San Clemente, CA 92673
949-248-4547

PATIENT REGISTRATION INFORMATION

Name: _____ What would you like to be called? _____
Last, First, MI

Home Address: _____
City: _____ State: _____ ZIP: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Date of Birth: _____ Age: _____ Sex: M F

Email address: _____

It is okay to send occasional emails: Yes _____

Social Security Number: _____ Occupation: _____

Employer's Name & Address: _____

If student: Full Time Part Time

Name of School: _____

Marital Status: Minor Single Married Widowed Divorced Separated

Name of Spouse (or Parents if Minor): _____

Patient's Medical Doctor (Internist/Family Practitioner/Pediatrician): _____

Address: _____ Phone: _____

Pharmacy name & phone number: _____

How did you hear about us? /Referred by? _____

Primary Medical Insurance _____ Secondary Medical Insurance _____

PAYMENT INFORMATION

Office Policy: Payment is expected at the time of your visit for any deductibles, co-payments, unpaid Medicare or insurance balances and any cosmetic procedures or skin care products. We appreciate your cooperation in settling your account at each office visit. If your insurance plan is responsible for payment, please present your insurance card to our reception desk.

Do we have permission to: Leave a message on your answering machine at home? Yes _____ No _____

Leave a message at your place of employment? Yes _____ No _____

Leave a message on your cell phone? Yes _____ No _____

Discuss your medical condition with any member of your household? Yes _____ No _____

If yes, whom: _____ Relationship _____

Emergency Contact: _____ Relationship _____ Phone _____

Signature Date

HIPAA FORM COPY ACKNOWLEDGEMENT (attached)

Signature below is only acknowledgement that you have received a copy of our Privacy Practices.

Print Name _____ Signature _____ Date _____