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ocean state dermatology

Phone: 401-585-6020
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Email: info@osderm.com

Patient Registration Form

Welcome! Thank you for choosing Ocean State Dermatology.

Please completely fill out this form to ensure the fastest and best healthcare service.

Patient's Name: _____ Date: _____

Sex: M____ F____ Marital Status: Married____ Single____ Divorced____ Widow____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____ Birthdate: _____ Age: _____

Email: _____ May we send information here? (circle one) YES NO

Occupation: _____ SSN: _____

Employer: _____ Years There: _____ Work Phone: (____) _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Complete this section only if someone other than the patient is financially responsible:

Responsible Party: _____ Relationship to Patient: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____ Birthdate: _____ Age: _____

Employer: _____ Years There: _____ Work Phone: (____) _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

Name of Spouse: _____ Birthdate: _____ Age: _____

Occupation: _____ SSN: _____

Employer: _____ Years There: _____ Employer's Telephone: (____) _____

Employer's Address: _____

City: _____ State: _____ Zip: _____

In case of emergency, contact: _____ Relationship: _____

Home Phone: _____ Work Phone: (____) _____

How did you learn about our practice? (friends, family, internet, website, other) _____

Continued on reverse side >

Name & Address of Primary Care Physician: _____

Name of Referring Physician (if different from Primary Care Physician): _____

Do you wish for correspondence to be confidential? (circle one) YES NO

Do you wish for phone calls to be confidential? (circle one) YES NO

May we contact you at work? (circle one) YES NO

If you would like us to discuss your personal health information such as results with someone other than yourself, please indicate below

Name: _____ Relationship: _____

INSURANCE INFORMATION:

Patient's Name: _____ Date: _____

PRIMARY INSURANCE:

Name of Insurance Company: _____

Address: _____

City:_____ State: _____ Zip: _____

Insured's Name: _____ Group #: _____ Policy ID #: _____

SECONDARY INSURANCE:

Name of Insurance Company: _____

Address: _____

City:_____ State: _____ Zip: _____

Insured's Name: _____ Group #: _____ Policy ID #: _____

Our office will file insurance for all reimbursable services, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductible, copay, and non-covered service amounts. See our complete financial policy for details.

Method of Payment for Today's Visit: (circle one) Cash Check VISA/MC/Discover

Signature of Patient or Responsible Party: _____ Date: _____

I authorize the release of any medical information necessary to process my claim.

Signed: _____ Date: _____
(patient or responsible party)

I authorize payment of medical and surgical benefits to _____, MD.

Signed: _____ Date: _____
(patient or responsible party)