PETERSON DERMATOLOGY

Patient Registration and Consent to Treat Form

PATIENT INFO	FIRST/MIDDLE/LAST NAME		
	DOB	SSN	MARITAL STATUS *(CIRCLE ONE)* Single Married Divorced Widowed
	HOME ADDRESS		
	EMAIL ADDRESS		
	HOME PHONE #	WORK PHONE #	MOBILE PHONE #
	PRIMARY CARE PHYSICIAN	EMPLOYER	
	EMERGENCY CONTACT NAME	EMERGENCY CONTACT'S PHONE #	
	PHARMACY NAME	PHARMACY PHONE #	
RESPONSIBLE	**PERSON RESPONSIBLE FOR PAYMENT IF PATIENT IS UNDER AGE 18**		
	FIRST/MIDDLE/LAST NAME		
	HOME ADDRESS		
	HOME PHONE #	DOB	SSN
	EMPLOYER NAME	EMPLOYER PHONE #	
INSURANCE INFO	PRIMARY INSURANCE		
	PRIMARY INSURANCE ADDRESS		
	PRIMARY INSURED NAME	DOB	
	SUBSCRIBER ID #	GROUP #	RELATION TO PATIENT
	SECONDARY INSURANCE		
	SECONDARY INSURANCE ADDRESS		
	SECONDARY INSURED NAME	DOB	
	SUBSCRIBER ID #	GROUP #	RELATION TO PATIENT
CONSENT	**Consent to Treat:** I consent to examination, diagnosis, and general medical care and treatment (including, but not limited to, physical examinations, administration of medications, diagnostic tests, laboratory tests, and other minor procedures) to be performed by office personnel, including physicians, nurses, and assistants. Patient Signature: _____ Date: _____		