

**VENICE DERMATOLOGY CLINIC, P.A.**  
**PATIENT REGISTRATION FORM**

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Marital Status:  Married  Wid  Divorced  Single  Separated  Other

Local Address: \_\_\_\_\_  
\_\_\_\_\_

Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ Other: \_\_\_\_\_

Email Address: \_\_\_\_\_

Northern Address (if applicable):  
\_\_\_\_\_  
\_\_\_\_\_

Seasonal Phone Number: \_\_\_\_\_ Dates From: \_\_\_\_\_ To: \_\_\_\_\_

Employed  Full Time Student  Part Time Student  Retired

Spouse / Significant Other / Parent or Guardian: \_\_\_\_\_

Employer / School: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Referred by:  Newspaper  Ins. Company  Physician  Other (please specify): \_\_\_\_\_

Primary Doctor: \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

**PLEASE COMPLETE OTHER SIDE OF FORM**

# INSURANCE INFORMATION

Primary Insurance Company: \_\_\_\_\_

Policy Holder Name (if different than patient): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
\_\_\_\_\_

Policy ID Number: \_\_\_\_\_ Group Name or Number: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Policy Holder Name (if different than patient): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
\_\_\_\_\_

Policy ID Number: \_\_\_\_\_ Group Name or Number: \_\_\_\_\_

**Medicare Release Signature:** I authorize any holder of medical or other information about me to be released to the Social Security Administration and the Center for Medicare and Medicaid Services or its intermediaries or carriers, and my Medicare supplemental insurance carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to Venice Dermatology Clinic, PA.

\_\_\_\_\_  
Patient/Parent Signature Date

**Financial Policy:** Claims will be forwarded to your insurance carrier for processing. I understand that co-pays and deductibles are collected at a time of service and that I am responsible for any collection costs for non-payment, should action become necessary.

\_\_\_\_\_  
Patient/Parent Signature Date

**PLEASE PRESENT YOUR INSURANCE CARD(S) AND PHOTO ID TO RECEPTION**