PLACER DERMATOLOGY
& Skin Care Center
9285 Sierra College Blvd., Roseville, CA 95661
Phone (916) 784-3376 Fax (916) 784-9500

If possible, please fax, send, or bring completed forms with you to the appointment.

Patient Registration Information

Patient Name: _____ **Today's Date:** _____
Last First M.I.

Date of Birth: ____/____/_____ Age: _____ Gender: ○ Male ○ Female

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed

SSN: _____ Occupation: _____ Employer: _____

Home Address: _____
City State Zip

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

Cell Phone: ( )_____ e-mail: _____

May we leave personal medical information on your:

Home answering machine? ○ Yes ○ No Cell Phone? ○ Yes ○ No Work Phone? ○ Yes ○ No

Do you give our office permission to discuss your medical information with family members? ○ Yes ○ No

Name: _____ Phone: ( )_____

Relationship to patient: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: _____ Date of Birth: ____/____/_____
Last First M.I.

Relationship to patient: _____ Address: **Same as above** ☐

or_____
City State Zip

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

In case of emergency, whom should we notify?

Same as above ☐ Ũb, t ame: _____

Address: _____
City State Zip

Relationship to patient: _____ Phone: ( )_____

HOW DID YOU LEARN ABOUT PLACER DERMATOLOGY? Please specify. Thank you.

○ **FAMILY/FRIEND** ○ **COMPASS** ○ **GRANITE BAY VIEW**
○ **PHONE BOOK** ○ **INTERNET** ○ **STYLE MAGAZINE** ○ **OTHER**

PRIMARY INSURANCE

Name of Insurance Company:_____

Address: _____
City *State* *Zip*

Name of Policy Holder (insured): _____ Date of Birth: ___/___/____

Policy Number: _____ Group Name or Number: _____

Policy Type: ○ HMO ○ PPO ○ Other_____

Relationship to patient: _____

SECONDARY INSURANCE

Name of Insurance Company:_____

Address: _____
City *State* *Zip*

Name of Policy Holder (insured): _____ Date of Birth: ___/___/____

Policy Number: _____ Group Name or Number: _____

Policy Type: ○ HMO ○ PPO ○ Other_____

Relationship to patient: _____

REFERRING PHYSICIAN

Name: _____ Phone Number: ( )_____
Last *First* *M.I.*

PRIMARY CARE PHYSICIAN ☐ Same as above

Name: _____ Phone Number: ( )_____
Last *First* *M.I.*

PHARMACY OF CHOICE

Name: _____ Phone Number: ( )_____

Address:

_____
City *State* *Zip*

AUTHORIZATIONS

I authorize the release of medical information to my primary care or referring physician, to any consultants as needed, and as necessary to process insurance claims and prescriptions.
I have received and/or reviewed a copy of the Notice of Privacy Practices from Placer Dermatology.
I authorize Placer Dermatology to take digital photographs for my medical record if medically necessary.

Signature: _____ Date: _____

Our office will file insurance for all reimbursable service, to both your primary and secondary insurance carriers. Please remember that you are responsible for all deductable, copay, and non-covered service amounts at the time of your visit.

Please present your insurance card(s) and your photo ID to the receptionist at check in. Thank you.