BELLAIRE DERMATOLOGY

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Patient Registration Form

Please provide the following information if you are a new patient, your information has changed since your last visit, or if it has been 12 months or longer since your last visit. Thank you for your time and cooperation.

Last Name _____ First Name _____ Middle Initial _____

Street Address _____ City _____ State _____ Zip Code _____

Social Security Number _____ Date of Birth _____ Marital Status (circle one): Single / Married / Other

Home Phone Number _____ Cell Phone Number _____ Work Phone Number _____

Email Address _____ **Referred by** _____

Gender (circle one): M / F M

Preferred Language (circle one): English / Spanish / Other English

Ethnicity (circle one): Hispanic or Latino / Not Hispanic or Latino Not Hispanic or Latino

Race (circle one) ○ Not Disclosed ○ White ◉ Black or African American ○ Asian ○ American Indian ○ Multi-Racial

I understand that by signing this form, I certify that all information provided is accurate to the best of my knowledge. I have been provided a copy of the HIPAA Privacy Practices and have read and understood the policy. I have also been provided a copy of the Financial Policy Practices and agree to the terms.

I understand that my contact information will not be shared with any other third parties for solicitations, but that I will receive reminders about upcoming appointments.

Patient or Guarantor's Signature _____ **Date** _____