



REGISTRATION FORM

Dermatology and Oculoplastic Consultants

Provider: Anderson / Brannan

Today's Date ___/___/___

PATIENT INFORMATION

NAME _____ Birth Date ___/___/___ Age _____
Last First M.I.

SSN _____ Sex ___ Male ___ Female

Florida Address _____ City _____ State _____ Zip _____

Out of Town Address _____ City _____ State _____ Zip _____

Home Phone () _____ Cell Phone () _____

Work Phone () _____ e-mail _____

Occupation _____ **Employer** _____

Physician _____ **Phone ()** _____

Pharmacy _____ **Phone ()** _____

Referred to Clinic by ___Physician ___Insurance ___Family / Friend ___Lecture
please check ___Newspaper ___Internet ___Phone book ___Mailer

Emergency Contact _____
Name Phone # Relationship

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

Address _____
City State Zip

Home Phone () _____ Call / Work Phone () _____

INSURANCE INFORMATION - PRIMARY:

Policy Holder's Name (subscriber's) _____

Policy Holder's Birth Date ___/___/___ SSN: _____

Insurance Co. Name _____ Policy Type ___HMO ___ PPO

Policy # _____ Group # _____

Relationship to you ___ Self ___ Spouse ___ Parent

INSURANCE COVERAGE - SECONDARY:

Policy Holder's Name (subscriber's) _____

Policy Holder's Birth Date ___/___/___ SSN: _____

Insurance Co. Name: _____ Policy Type: ___HMO ___ PPO

Policy #: _____ Group # _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Heidi K. Anderson, MD, and/or Paul A. Brannan, MD, or any other health care professional of Dermatology Associates, PA to release any information required to process my claims.

Patient / Guardian Signature _____ Date ___/___/___

Partnered with Dermatology Associates, PA of Palm beaches