



# 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 \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone ( ) \_\_\_\_\_

*please check one* Referred to Clinic by : Name of ref Physician \_\_\_\_\_ Insurance \_\_\_\_\_ Name of Family / Friend \_\_\_\_\_

Lecture \_\_\_ 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:

Insurance Co. Name \_\_\_\_\_ Policy Type \_\_\_ HMO \_\_\_ PPO

Policy Holder's Name (subscriber's) \_\_\_\_\_

Policy Holder's Birth Date \_\_\_/\_\_\_/\_\_\_ Relationship to you \_\_\_ Self \_\_\_ Spouse \_\_\_ Parent

**Does your insurance company require referrals:** \_\_\_\_\_

### INSURANCE INFORMATION- SECONDARY:

Insurance Co. Name \_\_\_\_\_ Policy Type \_\_\_ HMO \_\_\_ PPO

Policy Holder's Name (subscriber's) \_\_\_\_\_

Policy Holder's Birth Date \_\_\_/\_\_\_/\_\_\_ Relationship to you \_\_\_ Self \_\_\_ Spouse \_\_\_ Parent

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, to release any information required to process my claims.

Patient / Guardian Signature \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_