Johnson Dermatology Patient Registration Form

Patient Information

Full Name:		Date of Birth:
Mailing Address or P.O. Box:		
City, State, and Zip Code:		
Social Security Number:		Sex: □Male □ Female
Phone:	Home:	Mobile:
Employer:		Phone:
Email Address:		
Marital Status	□ Single □ Divorced □ Married □ Widowed	Preferred Language □English □ Spanish □ Other:
Race / Ethnicity	□Asian □Black □ Caucasian □Hispanic □Native American □ Other (please specify):	

Parent or Guardian Information

(complete only if the patient is less than 18 years old)

Full Name:		Relationship:
Address:		
Social Security Number:		Date of Birth:
Phone:	Home:	Mobile:
E-mail Address:		

Authorization to Release Health Information

□ Only discuss my healthcare with me.

List any individuals with whom we can discuss your care – for example, your spouse or child.

Person One	Name:	Date of Birth:
	Phone Number:	
	Relationship to Patient:	
Person Two	Name:	Date of Birth:
	Phone Number:	
	Relationship to Patient:	
Person Three	Name:	Date of Birth:
	Phone Number:	
	Relationship to Patient:	

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Primary Insurance Information		
Insurance Carrier:		
ID Number:		Group Number:
Address of Insurance Co:		
Subscriber:		Relation to Patient:
Social Security Number:		Date of Birth:
Phone:	Home:	Mobile:
Email:		
Employer:		Phone:

Secondary Insurance Information ☐ **Check if Not Applicable.**		
Insurance Carrier:		
ID Number:		Group Number:
Address of Insurance Co:		
Subscriber:		Relation to Patient:
Social Security Number:		Date of Birth:
Phone:	Home:	Mobile:
Email:		
Employer:		Phone:

Primary Pharmacy Information
Name of Pharmacy:
Location:
Phone: