Patient Registration Form

Name:_____ Gender: M / F

Ethnicity: Hispanic or Latino
Not Hispanic or Latino
Unknown

Race: American Indian or Alaska Native
Black or African American
Native Hawaiian or Other Pacific Islander
Asian
White
Other Race

*The above information is collected per a government initiative

Address:_____ Date of Birth:_____

City:_____State:_____Zip:_____ Social Security #:_____

E-mail address:_____ ☐ I do not wish to receive emails

Marital Status: Married Single Divorced Widow(er) other Telephone (home):_____

Primary Care Physician:_____ Telephone (cell):_____

Refered by:_____ Telephone (work):_____

Emergency Contact Name:_____ Telephone #:_____

Preferred Pharmacy Name:_____ Street & City:_____

Employer name & address:_____

Primary Insurance Name:_____

Insurance ID:_____ Group #:_____

Policy holder name:_____

Policy holder address:_____ Date of birth:_____

Policy holder telephone #:_____ Social Security #:_____

Relationship of patient to the policy holder:_____

Insurance address:_____

Insurance telephone #:_____

Secondary Insurance Name:_____

Insurance ID:_____ Group #:_____

Policy holder name:_____

Policy holder address:_____ Date of birth:_____

Policy holder telephone #:_____ Social Security #:_____

Relationship of patient to the policy holder:_____

Insurance address:_____

Insurance telephone #:_____

Patient's or Responsible Party Signature:_____ Date:_____

The information provided above is correct. I will be responsible in full for any charges that are not covered by my insurance carrier(s). I authorize release of any medical information to my primary and referring physicians and consultants if needed, and as necessary to process a claim for payment of medical benefits to Wendy Sadoff MD Dermatology PC. I have received and have had the opportunity to review a copy of the Notice of Privacy Practices.

May we discuss your medical information with another person (circle one)? YES NO
If yes, please print the individual(s) name and relationship to you:

_____

Signature:_____Date:_____

Mail to: Sadoff Dermatology PC, 31360 Northwestern Highway, Farmington Hills, Michigan 48334
or Fax to: 248.855.3319