

ADULT AND PEDIATRIC DERMATOLOGY OF TULLAHOMA, P.C.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT NAME				PREFERRED NAME		TITLE (CIRCLE ONE)					
Last	First	Middle	Jr./Sr.			MR	MRS	MS	MISS		
ADDRESS			Street Address - P. O. Box		Apt. #		City		State		Zip
PHONE #				SEX		DATE OF BIRTH		SOCIAL SECURITY NUMBER			
HOME				MOBILE		MALE FEMALE					
REFERRED BY			IF STUDENT (CIRCLE ONE)			NAME OF SCHOOL					
			FULL TIME			PART TIME					
PATIENT'S EMPLOYER				1) PRIMARY INSURANCE				WORK PHONE #			
				2) SECONDARY INSURANCE							
EMPLOYER'S ADDRESS			Street Address				City		State		Zip
WHERE SHOULD STATEMENTS OF YOUR ACCOUNT BE SENT IF DIFFERENT FROM ABOVE?		Name		Street Address - P.O. Box - Apt. #			City		State		Zip
SPOUSE'S NAME					DATE OF BIRTH		SOCIAL SECURITY NUMBER				
SPOUSE'S EMPLOYER					CELL PHONE #		SPOUSE'S WORK PHONE #				
LEGAL GUARDIAN OR PARENT NAME				SOCIAL SECURITY #			HOME PHONE #			DATE OF BIRTH	
EMPLOYER					CELL PHONE #			WORK PHONE #			
EMPLOYER'S ADDRESS			Street Address				City		State		Zip

INSURANCE INFORMATION*

*PLEASE PRESENT INSURANCE CARD AT TIME OF CHECK IN

PRIMARY INSURANCE CARRIER	SECONDARY INSURANCE CARRIER	
INSURANCE COMPANY	INSURANCE COMPANY	
INSURANCE COMPANY'S ADDRESS	INSURANCE COMPANY'S ADDRESS	
INSURED'S NAME	INSURED'S NAME	RELATIONSHIP TO PATIENT
IDENTIFICATION NUMBER	IDENTIFICATION NUMBER	GROUP NUMBER

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received and/or read a copy of Adult and Pediatric Dermatology of Tullahoma, PC's Notice of Privacy Practices. This notice describes how Adult and Pediatric Dermatology of Tullahoma, PC may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and rights I may have regarding my protected health information.

AUTHORIZATIONS

Do we have permission to:

Leave a message on your answering machine at home? Yes No

Leave a message at your place of employment? Yes No

Discuss your medical condition with any member of your household? Yes No

If yes, whom: _____ Relationship _____

whom: _____ Relationship _____

whom: _____ Relationship _____

Please initial: _____ I authorize Dr. Ken Takegami or Ashley Messick, PA to treat my unaccompanied minor child, _____ in my absence.

Patient / Parent / Legal Guardian Signature

Date