ADULT AND PEDIATRIC DERMATOLOGY OF TULLAHOMA, P.C.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

PATIENT NAME Last First Middle Jr./Sr.			PREFERRED NAME	TITLE (CIRCLE ONE) MR MRS MS MISS
ADDRESS Street Address - P. O. Box Apt. #			City	State Zip
PHONE # HOME MOBILE			SEX MALE FEMALE	DATE OF BIRTH / SOCIAL SECURITY NUMBER
REFERRED BY	IF STUDENT (CIRCLE ONE) FULL TIME PART TIME		NAME OF SCHOOL	
PATIENT'S EMPLOYER	1) PRIMARY INSURANCE 2) SECONDARY INSURANCE			WORK PHONE #
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

AKNOWLEDGEMENT 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*