Rocky Mountain DERMATOLOGY

# Patient Registration

## Welcome!

Today's Date _____ DOB _____

Patient Name _____ □ Male □ Female

**If patient is a minor, please list parent's names:**

Mother _____ Father _____

**What number(s) is it OK to leave messages containing medical, personal or billing information?**

□ Home _____ □ Work _____ □ Cell _____ □ None

**Email Address** _____

**What pharmacy do you use?** _____ Location _____

**Primary Care Physician's Full Name** _____ City _____

Who may we thank for referring you to our practice?□ PCP □ Other _____

**Race:**_____ **Ethnicity:**_____ **Language:** □ English □ Other _____

**Name & Address of the Person Financially Responsible**

Name:_____

Street Address _____

City _____ State _____ Zip _____

Home # _____ Work # _____ Cell # _____

**Emergency Contact**

Name _____ Relationship _____

Home # _____ Work # _____ Cell # _____

**To whom may we release your medical, personal or billing information? Please list:**

Name _____ Relation _____ DOB _____

Name _____ Relation _____ DOB _____

(If someone's name is not listed, even a family member, we can not release information to them. A written withdraw will be required to remove these privileges)