WILSON DERMATOLOGY & SKIN CARE
PATIENT REGISTRATION
(Please Print)

Today's date:	

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Street address:	Birthdate	Home Phone # ( )

City	State / Zip Code	Work Phone #	Cell Phone # ( )

Primary Care Physician	Primary Care Address	Primary Care Phone # ( )

Email for Confirmations:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Please indicate primary insurance ❑ Aetna ❑ BCBS ❑ UHC ❑ Cigna ❑ Other

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of Emergency Contact	Relationship to patient:	Home phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Wilson Dermatology & skin care or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*