

Yale Dermatology Associates, PC ~ 2 Church St South ~ New Haven CT 06519

PATIENT REGISTRATION FORM- Please print

Patient Information

Name _____
Last First Middle Initial

Address _____
Street City State Zip

Phone # _____ Phone # _____
home cell

Date of Birth _____ Sex _____ SS# _____

Parent or responsible party (if different from patient)

Name _____
Last First Middle Initial

Address _____
Street City State Zip

Phone # _____ Phone # _____
home cell

Date of birth _____ Sex _____ SS# _____

Insurance Information (please present insurance card at time of visit)

Insured is the name of the person who carries the insurance, not always the patient

Primary Insurance Carrier: _____

Relationship of patient to insured: self spouse child other

Name of Insured _____

Insured DOB _____ ID # _____

Group Number _____

Secondary Insurance Carrier: _____

Relationship of patient to insured self spouse child other

Name of Insured _____

Insured DOB _____ ID# _____

Group Number _____

Referring Physician:

Name address telephone

Primary Care Physician:

Name address telephone

Emergency Contact: _____ relation _____ Phone # _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Date _____

Copy of insurance card (both sides) attached

Updated By: _____