BRENTWOOD SKIN CLINIC PATIENT REGISTRATION

Today's Date: _____

Patient First Name: _____

Patient Last Name: _____

Birth Date: _____/_____/_____ Please Circle: Male Female Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Email: _____

Marital Status (Please circle one): Married Single Widowed Other

How did you hear about us? (Please circle): Family/Friend Internet Other: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Pharmacy (name, city and phone number):_____

_____ (**Initial**) I have received, reviewed and AGREE to the FINANCIAL POLICY.

_____ (**Initial**) I have received, reviewed and agree to the HIPAA Notice of Privacy Practices document.

RESPONSIBLE PARTY (if different than patient)

First Name:_____Last Name:_____MI _____

Street Address _____

City_____State_____Zip _____

Birth Date_____/_____/_____ Phone # _____

Please initial all that apply:

_____The staff of Brentwood Skin Clinic may leave a detailed message on voice mail
_____The staff of Brentwood Skin Clinic may speak **ONLY** to the patient
_____ The staff of Brentwood Skin Clinic may speak with the following person(s):

Name(s): _____ Relationship to Patient: _____

Signature of Patient: _____