TWIN PORTS
Dermatology

ANNUAL PATIENT REGISTRATION FORM

-PLEASE PRINT & FILL OUT THE FORM COMPLETELY-

PATIENT INFORMATION

First Name:		Last Name:		Middle Initial:	
Is this your legal name? ☐ Yes ☐ No		If no, what is your full legal name?			
Prefers to be called:		If under 18, list guardians name:			
Pronouns ☐ He/him ☐ She/her ☐ They/them	Gender:	Birth Date: / /	Age:	Height:	Weight:
	Primary Phone #: ( )		**Secondary Phone #: ( )**		
	Want access to your Patient Portal? ☐ Yes ☐ No		Email:		
Street Address:			P.O. Box:		
City:	State:		ZIP Code:		

MEDICATION, VACCINATION, & ALLERGY HISTORY

Please list all prescription and over-the-counter medications you are currently taking (i.e. pain relievers, vitamins/supplements, or baby aspirin). Include dose and frequency: _____

_____

Please list all known allergies: _____

_____

Do you have a health care directive? ☐ Yes ☐ No | Please list your Primary Care Provider:

SIGNATURES

Do we have permission to leave a message regarding your care at the phone number you have provided? ☐ Yes ☐ No

Is there anyone you approve for us to discuss your medical care with (spouses, parents, children, caregivers, living facilities, etc.)? If so, please list name(s):

Initials: _____ I have read Twin Ports Dermatology's Patient Financial Policy. I know of the required 24-hour notice for cancellation/rescheduling and failure to do so will result in a $50 fee.

Initials: _____ I have read Twin Ports Dermatology's Notice of Privacy Practices. I know I can ask for a copy at any time.

Initials: _____ I have read Twin Ports Dermatology's HIPAA Acknowledgement Form.

Assignment of Benefits and Related Release of Information: I request payment of authorized benefits directly to the provider for services furnished to me at this facility or any other facility owned or utilized by Twin Ports Dermatology. I consent to the release of medical and other information related to such services for healthcare operations; and to Medicare, my insurance company, other third party payers, in order to process and pay claims, determine benefits, and perform quality of care reviews. In the event that my health plan determines a service to be "not covered", I will be responsible for those charges in full.

The above information is true to the best of my knowledge.

Patient/Guardian Signature: _____ ***Date:*** _____