Lake Dermatology Medical Associates

Lake Dermatology Medical Associates
5144 Hill Road East, Lakeport, CA 95453
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REGISTRATION INFORMATION

PATIENT INFORMATION				DATE:	
LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #	
HOME ADDRESS	CITY	STATE	ZIP	SEX: ☐MALE ☐FEMALE	
SPOUSE'S NAME	HOME #		WORK #		
EMAIL ADDRESS	MOBILE #		MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED		
RESPONSIBLE PARTY INFORMATION (If other than self)					
LAST NAME	FIRST NAME	MI	HOME #		
ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #	
EMPLOYER	OCCUPATION		WORK #		
EMPLOYER'S ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY ☐ SPOUSE ☐ SON ☐DAUGHTER	
EMERGENCY INFORMATION					
NAME	RELATIONSHIP		HOME #		
ADDRESS	CITY	STATE	ZIP	WORK #	
PRIMARY INSURANCE	SOCIAL SECURITY #	CARDHOLDER	DATE OF BIRTH		
GROUP NUMBER	IDENTIFICATION NUMBER	EFFECTIVE DATE			
ADDRESS	CITY	STATE	ZIP	PHONE NUMBER	
SECONDARY INSURANCE	CARDHOLDER	DATE OF BIRTH			
GROUP NUMBER	IDENTIFICATION NUMBER	EFFECTIVE DATE			
ADDRESS	CITY	STATE	ZIP	PHONE NUMBER	
PHARMACY INFORMATION- Must provide complete address information to ensure your prescriptions are sent to the correct pharmacy.					
PHARMACY NAME	PHARMACY PHONE NUMBER				
PHARMACY ADDRESS					

Patient Contact Preferences

Home Phone: It's ok to leave a message__________

Cell Phone: It's ok to leave a message__________

Work Phone: It's ok to leave a message__________

Written Communications

Okay to send written________________________

Okay to send written to home address_________

Okay to send written to work address _________

Email ____

Do you give the office of Lake Dermatology Medical Associates permission to discuss your medical information with family members? YES ____ NO ____ If Yes, Which Family Member?________________________________ Date ______

Signature ____ Date_________________