Mid Michigan Dermatology
Registration Information

Date: _____ Home Phone _____

Patient: _____
Last Name First Name Initial

Sex: M__ F__ Age: ____ Birth date:_____ SSN: _____

Circle: Single Married Widowed Separated Divorced Other

Email: _____

Responsible Party (if minor): _____

Home Address: _____
Street City State ZIP

Name of Employer: _____

Business Address: _____

Occupation: _____ Business Phone: _____

Purpose of Visit: _____

Your drugstore name: _____ Drug Store Phone: _____

In case of emergency, who should be notified? _____ Phone: _____

My signature acknowledges that the patient does not have Medicare or Medicaid insurance plan

Signature: _____ Date: _____

This office only participates and bills for certain insurance plans. Payment is otherwise expected at the time of service. My signature acknowledges that if my insurance is not one of the ones that this office participates with that payment will be made at the time of service. I plan to pay for services with:

Cash _____ Check _____ Charge Card _____

Signature: _____

Insurance Information for Those Insurance That This Office Participates With:

Insurance Co. Name _____

Address (Where to send claim): _____

Policyholder's Name: _____ Policy Number: _____

D.O.B.: _____ Social Security Number: _____