INITIAL PATIENT REGISTRATION FORM

Patient's Full Name: _____ Age:_____ Date of Birth: _____

Physical Address: _____ Last 4 SSN: _____

City, State, zip code:_____

Home:_____ Cell:_____ Work:_____

Gender: __ Male __ Female __ Ambiguous __Other __Unknown

Ethnicity: __Hispanic or Latin __ Not Hispanic or Latin __Unknown

Race: __White __American Indian or Native American __Black or African American

__ Native Hawaiian or Other Pacific Islander __Other_____

Preferred Language: __English __Spanish __Other

Email Address: _____

Employer:_____ Occupation:_____

Who is your Primary Physician/Provider? _____

Referring Physician/Provider if different? _____

Pharmacy Information:_____

Have you been seen by Dr. Reid or Dr. Bird at any office location within the past 3 years?
_____YES_____ NO

Who is your Emergency Contact: Name: _____Relationship: _____
Phone: _____

Concerning matters of my health, lab results, and appointments, I, the patient/patient representative give permission for staff at Embrace Dermatology and Aesthetics to speak to and share my information with the above Emergency Contact:

_____ Yes _____ No

EMBRACE DERMATOLOGY AND AESTHETICS, LLC
123 Chestnut Street, Suite 300
Philadelphia, PA 19106
909 Sumneytown Pike, Suite 105
Spring House, PA 19477
Phone: 267- 609- 2424 Fax: 267-609-2425

If you'd like us to share information with an additional or other contact, please provide the information below:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I ___ALLOW ___ DO NOT ALLOW test results and other specific information regarding my care to be left on my answering machine or voicemail.

The above information is accurate to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance.

I also authorize Embrace Dermatology and Aesthetics, LLC or insurance company to release any information required to process my claims.

Signature of Patient/Patient Representative: _____ Date: _____

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