Center for Advanced Dermatology

Minor Patient Registration Form

Minor's Information:

Legal Name: ____ Date of Birth: ______________ Age: _______
First Middle Last Month Day Year

Mailing Address: ____
Address /P.O. Box City State Zip Code

Primary Phone: ___________________ Work Phone: ___________________ Alternate Phone: ____________________
(Automated appointment reminder system calls **primary** number. ❑Check here if you do not want any reminder calls)

Gender____________ Name you prefer to be called by: ____

Primary Care Provider: _________________________ Who referred you to us: _______________________________

Parent/Guardian's Information (party responsible for payment):

Name: ____________________________________ ____
First Last Address City State Zip Code

Home Phone: ___________________ Work Phone: ___________________ Alternate Phone: ____________________

Insurance Information (required for processing an insurance claim on your behalf):

Primary Insurance Carrier: _________________________ Policy #: __________________ Group #: ________________

Name of Insured (Guarantor):________________________ Date of Birth: __________ Relationship: _________________

Employer: _______________________________________

Secondary Insurance Carrier: _______________________ Policy #: __________________ Group #: ________________

Name of Insured (Guarantor):________________________ Date of Birth: __________ Relationship: _________________

Employer: _______________________________________

As part of our efforts to adopt an electronic records system, please provide the following information:

Race (please circle one): White, American Indian, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, or Other

Preferred Language: _____________________________

Ethnicity (please circle one): Hispanic or Latino, Not Hispanic or Latino, or Unknown

I understand that I will be responsible for any monies (deductibles, co-pays, etc.) due that are not paid by my insurance.

Patient/Legal Guardian Signature: _____________________________________ Today's Date: _________________

Please complete the Consent to Treatment of Minors located on the back of this page.

After completing your paperwork, please present your insurance card(s) and your photo identification to the receptionist. The receptionist will make a copy and return them to you promptly.
Thanks for your cooperation.

June 2012