DERMWELLESLEY

**REGISTRATION INFORMATION**

Patient Name: _____ DOB: _____ Sex: M F

Address:_____

Home Phone: _____Cell Phone: _____ Leave Message: Y N

Email Address: _____ Referred By: _____

Primary Care Physician: _____Phone #: _____

Pharmacy Name: _____Address: _____

Emergency Contact:_____ Phone #: _____

Relationship: _____

Primary Insurance Name: _____ID #: _____

Group #: _____Phone #: _____

Subscriber Name: _____ DOB: _____

Relationship to Patient: _____

Secondary Insurance Name: _____ID #: _____

Group #: _____Phone #: _____

Patient/Guardian Signature: _____ Date: _____

Relationship to Patient: _____

Contact Information: _____

I verify that the above information is correct. I have reviewed the DermWellesley, LLC Privacy Practices (available on our website or in office). This notice reviewed how DermWellesley, LLC can use and disclose my protected health information and what my rights are regarding my protected health information. Any questions or concerns can be addressed with DermWellesley, LLC HIPAA compliance officer (Wendy Nickerson)

Signature: _____Date:_____