Bel-Ami Dermatology, **Kay A. Johnston, M.D**.

Patient Registration Form

Patient ID# _____

_____ _____
(First, Middle, Last, Suffix) (Date of Birth)

_____ ○ Mr. ○ Mrs. ○ Ms. ○ Miss ○ Dr. _____
(Preferred to be called) (Social Security Number)

_____ _____ ⬭ Male
(Mailing Address) (Home telephone #)

_____ _____ _____ ⬭ Female
(City, State, Zip) (Cell phone #) (Cell Phone Carrier)

_____ ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated
(E-mail Address)

Employment Information

_____ _____
(Occupation) (If **retired**, from what did you retire?) (Employer)

_____
(Address)

_____ _____
(Work telephone number) (City, State, Zip)

If patient is a minor, _____ _____ _____
(Name of parent or guardian) (Day telephone #) (Evening telephone #)

As required by law, children under age 18 must be accompanied by a parent for their first visit.

Spouse's Information (if applicable)

_____ _____ _____
(Spouse's Name) (Spouse's Employer) (Spouse's Employer telephone #)

_____ _____ _____
(Spouse's Date of Birth) (Spouse's Social Security Number) (Spouse's phone number)

Reference Information

_____ _____ _____
(Primary Care Physician) (telephone #) (Pharmacy Name & Location) (telephone #)

In case of emergency, whom should we notify? _____ _____ _____
(Name) (Relationship) (telephone #)

Responsible Party (if other than patient): _____ _____ _____
(Name) (Relationship) (Daytime telephone #)

_____ _____ _____
(Mailing Address) (Employer) (Evening telephone #)

_____ _____ _____
(City, State, Zip) (Employer telephone #) (Social Security Number)

CANCELLATION NOTICE: We respectfully request that if you are unable to keep your scheduled appointment, please call us 24 hrs in advance to avoid a Missed Appointment fee. We can be reached at (325) 944-3376.

SEE BACK ➡

Registration Form Con't.

Insurance Holder/Subscriber Information

○ A staff member made a copy of my card(s)

○ If visit is only cosmetic, I understand that my insurance will not pay.

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Subscriber's Information (if other than patient): _____
(relationship to patient)

_____ _____ _____
(Name) (Date of Birth) (Subscriber's Social Security Number)

Signature on File

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I authorize payment of medical benefits to Bel-Ami Dermatology for services rendered. I also acknowledge responsibility for payment of all medical fees regardless of any insurance I may have. If for any reason the account should become delinquent, I agree to pay for all collection and legal fees.

_____ _____
(Patient or Responsible Party Signature) (Date)

I authorize the following to be done concerning my medical information:

You may leave a message on my answering machine at home: [ ]Yes [ ]No

You may leave a message at my place of employment: [ ]Yes [ ]No

You may discuss my medical condition with my spouse/family member [ ]Yes [ ]No

Spouse/Family member's Name: _____ (relationship) _____
Phone # _____

Email Address: _____

These are the following individuals whom you may discuss my medical care with:

_____ _____ _____
Name Relationship Phone Number

_____ _____ _____
Name Relationship Phone Number

The above information is true to the best of my knowledge.

_____ _____
Patient or Other Legally Authorized Person Date