SANFORD DERMATOLOGY

REGISTRATION INFORMATION

PATIENT INFORMATION					**DATE:**
LAST NAME	FIRST NAME	MI	BIRTHDATE		SOCIAL SECURITY #
HOME ADDRESS	CITY		STATE	ZIP	SEX: ☐MALE ☐FEMALE
SPOUSE'S NAME	HOME #		WORK #		
EMAIL ADDRESS	MOBILE #		MARTIAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPERATED ☐ WIDOWED		
RESPONSIBLE PARTY INFORMATION (If other than self)					
LAST NAME	FIRST NAME	MI			HOME #
ADDRESS	CITY		STATE	ZIP	SOCIAL SECURITY #
EMPLOYER	OCCUPATION				WORK #
EMPLOYER'S ADDRESS	CITY		STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY ☐ SPOUSE ☐ SON ☐ DAUGHTER

EMPLOYMENT INFORMATION			
PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT	OCCUPATION	EMPLOYMENT OR STUDENT STATUS:	
PATIENT'S EMPLOYER OR SCHOOL ADDRESS		☐FULL-TIME ☐PART-TIME ☐SELF EMPLOYED	
CITY	STATE / ZIP	☐NOT EMPLOYED ☐ACTIVE MILITARY ☐RETIRED	

EMERGENCY INFORMATION				
NAME	RELATIONSHIP			HOME #
ADDRESS	CITY	STATE	ZIP	WORK #

INSURANCE INFORMATION ☐ PPO ☐ POS ☐ MEDICARE ☐ HMO CO-PAY $				
PRIMARY INSURANCE	SOCIAL SECURITY #	CARDHOLDER		DATE OF BIRTH
GROUP NUMBER		IDENTIFICATION NUMBER		EFFECTIVE DATE
ADDRESS	CITY	STATE	ZIP	PHONE NUMBER
SECONDARY INSURANCE		CARDHOLDER		DATE OF BIRTH
GROUP NUMBER		IDENTIFICATION NUMBER		EFFECTIVE DATE
ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

TRICARE INSURANCE INFORMATION-To be completed by TriCare patients only.		
SPONSORS NAME	DATE OF BIRTH	SOCIAL SECURITY #

PHARMACY INFORMATION-Must provide complete address information to ensure your prescriptions are sent to the correct pharmacy.			
PHARMACY NAME	PHARMACY PHONE NUMBER		
ADDRESS	CITY	STATE	ZIP