Dermatology Specialists of Pasadena

Patient Registration Form

Patient's Name (Last,First): _____ Date of Birth: _____

Sex: M /F / T Preferred Language: _____

Race:_____ Ethnic Group:_____

Contact Information: ▢Home Phone# _____
(Please mark preferred contact) ▢Work Phone# _____
▢Mobile Phone# _____
▢Email _____

Is it ok to leave a detailed message: ▢YES ▢NO
Is it ok for office to send appointment reminders: ▢YES ▢NO

Home
Address:_____

_____ _____ _____
City State Zip

Employment: _____ / _____ / Retired / Student
Employer Occupation/Profession

Marital Status: Married / Partner / Single / Divorced / Other
Emergency Contact:_____ _____ _____
Name Relation Phone #

Primary Physician/Provider: _____
Referring Physician/Provider: _____

PRIMARY INSURANCE

Policy Holder's Name:_____Relationship to patient:_____
Policy Holders Date of Birth: _____/_____/_____
Insurance Company Name:_____
Member ID:_____ Group ID:_____

Dermatology Specialists of Pasadena

SECONDARY INSURANCE (IF APPLIES)

Policy Holder's Name:_____Relationship to patient:_____
Policy Holders Date of Birth: _____/_____/_____
Insurance Company Name:_____
Member ID:_____ Group ID:_____

NOTICE OF PRIVACY ACT PRACTICES

HIPAA (Health Insurance Portability and Accountability Act) regulations requires us to provide you, the patient or personal representative a copy of our Notice of privacy practices and for you to sign as an acknowledgement of receipt.

Signature:_____ Date:_____

***Concerning matters of my health, lab results, and appointments, I, the patient/patient representative give permission for Dr. Zohrabian or members of her staff to speak to and share my information with:

___I do **NOT** want to share my information with anyone.

Same as Emergency Contact: Y/N. If different/additional:

Name: _____ Relationship: _____

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 Dermatology Specialists of Pasadena/Narineh Zohrabian MD Inc. or insurance company to release any information required to process my claims.

Signature of Patient/Patient Representative: _____ Date: _____