READING DERMATOLOGY
center for healthy skin

Patient Registration Form

3317 Penn Ave, West Lawn, PA 19609
Phone: 610-750-7891 | Fax: 610-750-7896
After Hours Urgent Matter Only 610-223-4871

Patient Information

Patient First Name: | Middle Name: | Last Name: | Date of Appointment:

Sex: Male/Female | Marital Status: Single/Mar/Div/Wid | Date of Birth: | Social Security Number:

Is this your legal name? Yes or No | If not, what is your legal name? | Maiden Name:

Patient's Address: | City: | State: | Zip Code:

Home Phone: | Mobile Phone: | Email Address:

Referred by: | Primary Care Physician: | Primary Care Physician Phone:

Pharmacy: | Pharmacy Address: | Pharmacy Phone:

Patient Employer/School Information

Employer/School: | Occupation: | Employer/School Phone:

Employer/School Address: | City: | State: | Zip Code:

Emergency Contact Information

Emergency Contact Name: | Emergency Contact Phone: | Relation to Patient:

Billing and Insurance

Primary Health Insurance

Insurance Company: | Plan:

Plan Number: | Group Number: | Insured's Employer/School:

Insured's Name: (as it appears on insurance card or ID) | Relation to Patient: | Insured's Phone Number:

Insured's Address: | City: | State: | Zip Code:

Insured's Social Security Number: | Insured's Birthdate:

Secondary Health Insurance

Insurance Company: | Plan: | Plan Number:

Group Number: | Insured's Employer/School: | Insured's Social Security Number:

Insured's Name: (as it appears on insurance card or ID) | Relation to Patient: | Insured's Phone Number:

Responsible Party

Billing Name: (if other than patient) | Phone: | Relation to Patient:

Address: | City: | State: | Zip Code:

The above information is true 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 Reading Dermatology Associates or my insurance company to release information required to process my claims.

Signature of Patient or Authorized Guardian | **Date**