Integrity Dermatology
1620 S 70th St # 103
Lincoln, NE 68506
402-318-3550

# PATIENT REGISTRATION FORM

**Patient Name:** _____

**Address:** _____ **City, State, Zip:** _____

**Sex:** Male Female **Birth Date:** _____/_____/_____ **Age**: _____ **Marital:** S / M / D / W

**Primary Phone:** ____-____-____ **Alternate Phone:** ____-____-____ **Email:** _____

**Employer & Phone:** _____

**Primary Physician & Phone:** _____

**Pharmacy & Location:** _____

**Emergency Contact:** _____ Relationship: _____

**Phone Number(s):** _____

## HOW DID YOU HEAR ABOUT US?

____ Physician ____ Friend ____ Website ____ Facebook ____ Other, Please Specify _____

Referring Physician or Referring Person(s) Name: _____

Are you currently enrolled in **Medicare and/or Medicaid? ___** YES ___ NO **(If YES, please see receptionist.)**

**FINANCIAL POLICY:** We are a Direct Pay dermatology practice and **DO NOT** participate with **ANY** insurance or government healthcare program (Medicare and Medicaid). Patients pay for their care at the time of service.

**Do you give our office permission to discuss your personal and/or financial information with family members?** _____ YES _____ NO

(If YES, please provide their names and phone numbers. *If left blank, the approval is invalid.*)

**Name and Phone Number(s):** _____ Relationship: _____

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**I/we hereby acknowledge receipt of Integrity Dermatology's Notice of Privacy Practices. _____Initials**

**I/we have read and understand the Financial Policy and Cancellation/No Show Policies. _____Initials**

*(If this form is completed prior to your appointment, please do not initial until you arrive at our office.)*

_____ _____

**Patient or Parent or Guardian Signature** **Date**