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

PATIENT REGISTRATION FORM

Patient Name: _____ **Preferred Name:** _____

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

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

Cell Phone: _____-_____-_____ **Alternate Phone:** _____-_____-_____

Email: _____

Employer: _____ **Phone:** _____

Primary Physician: _____ **Phone:** _____

Pharmacy: _____ **Location:** _____

Emergency Contact: _____ **Relationship**: _____

Phone Number: _____

HOW DID YOU HEAR ABOUT US?

_____ Physician _____ Family/Friend _____ Google _____ Facebook _____ Other, Please Specify _____

Name of Referring Individual: _____

Are you currently receiving any **Medicare and/or Medicaid** benefits? _____ YES _____ NO
(If YES, please notify the receptionist to complete the required form.)

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.

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

(Review Notice of Privacy Practices and Financial Policy in office or online before initialing.)

_____ _____
Patient or Parent/Guardian Signature (if under 19 years of age) **Date**