Robert B. Hopp, M.D. & Associates
Center for Excellence in Dermatology PLLC

REGISTRATION FORM

(Please Print)

Today's Date: _____

❒ Check here if you DO NOT want us to mail your biopsy results to you.

PATIENT INFORMATION

Patient's last name: First: M.I.:			Marital status (circle one): Minor / Single / Mar / Div / Wid / Partnered / for yrs
Email address:	Birthdate: / /	Age:	Sex: ❒ M ❒ F
Address:	Home phone no.: ( )		Cell phone no.: ( )
City:	State:	ZIP Code:	Social Security no:
Occupation:	Employer/School:		Employer/School phone no.: ( )
Employer's address:	City:	State:	ZIP Code:
Spouse's name:	Spouse's work phone no.:	Spouse's cell phone no.:	Spouse's Social Security no.:

You first found out about our office from (check ALL that apply): ❒ Referred by a doctor or medical office ❒ Insurance plan ❒ Radio ❒ Website/Online ❒ Yellow Pages ❒ Saw our building or sign ❒ Postcard ❒ Newsletter ❒ Chamber of Commerce ❒ Another patient/word of mouth ❒ Other:

❒ I would like to receive a text message for Appointment Reminders

Where do you look first when you need to find a phone number? ❒ In a phone book, or ❒ On the Internet

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Cell/home phone no.: ( )	Work phone no.: ( )

GUARANTOR INFORMATION (fill out if person responsible for bill is different than patient)

Guarantor's last name:	First:	Middle initial:	Birth-date: / /
Address (if different):	City:	State:	Zip code:
Occupation:	Employer:	Employer phone no.:	Social Security no.:

PARENTS OF MINOR

Mother's last name: First: M.I.:	Father's last name: First: M.I.:

INSURANCE INFORMATION

Insurance company:	Subscriber's **FULL** name:	Subscriber ID no.:	Group no. (if applicable):
Patient's relationship to subscriber:	Subscriber's employer:	Subscriber's S.S. no.:	Birth-date: / /

SECONDARY INSURANCE

Is patient covered by additional insurance? ❒ YES ❒ NO If **YES**, this section **MUST** be **COMPLETELY** filled out.

Insurance company:	Subscriber's **FULL** name:	Subscriber ID no.:	Group no. (if applicable):
Patient's relationship to subscriber:	Subscriber's employer:	Subscriber's S.S. no.:	Birth-date: / /

MEDICARE ONLY

Does patient live in a skilled nursing facility? ❒ YES ❒ NO Is patient currently under hospice care? ❒ YES ❒ NO