HELEN SHIM, M.D., PLLC

DERMATOLOGY/DERMATOPATHOLOGY

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	**First:**	middle	**Marital status:**

Is this your legal name?	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex:
○ Yes ○ No			____/____/____		○ M ○ F

Address: **City** **State** **Zip Code**

Social Security no.:	Home phone no.:	Cell phone no.:
Pharmacy Name:	Address:	Pharmacy phone no.:

Referred to clinic by (Please choose one option): ○ Doctor's Name: _____

○ Insurance, Friend, Internet, Patient, etc._____

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.) copy taken: ○ Yes ○ No

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
Is this person a patient here?	○ Yes ○ No	Is this patient covered by insurance?	○ Yes ○ No
Occupation:	Employer:	Employer address:	Employer phone no.:

Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment:

Patient's relationship to subscriber (Circle One): Self, Spouse, Child, Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber (Circle One): Self, Spouse, Child, Other

IN CASE OF EMERGENCY

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

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 HELEN SHIM, M.D., PLLC DERMATOLOGY or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date

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