PETER B. ODLAND, M.D.
ANNALISA K. GORMAN, M.D.
JODI S. MARKUS, M.D.

SKIN SURGERY CENTER
SKIN CANCER SPECIALISTS

SARAH B. PATTON, PA-C
NICOLE M. MARSHALL, PA-C
RACHEL A. PARINE, PA-C

PATIENT REGISTRATION:

Name: _____
Last First M.I.

Date of Birth: _____/_____/_____ Marital Status (optional): _____ Sex: ❑ Male ❑ Female

Mailing Address: _____
City State Zip

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

E-Mail: _____
OK to communicate via E-mail? ❑ Yes ❑ No (I understand that E-mail may not be a secure means of communication.)

REFERRAL INFORMATION:

Referred by: _____ ❑ Physician ❑ Friend/ Family ❑ Other

Physician Phone: ( ) _____

Primary Care Physician: _____ PCP Phone: ( ) _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(IF DIFFERENT FROM PATIENT)*:

Name: _____ Date of Birth: _____/_____/_____
Last First M.I.

Address: _____
City State Zip

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

INSURANCE INFORMATION: Please provide your insurance card(s) & driver's license (or other photo I.D.) to the receptionist.

Is your insurance a managed care plan that requires a referral from your primary care doctor? ❑ Yes ❑ No		
	Primary Insurance	**Secondary Insurance**
Name of Insurance		
Insurance Through Employer?	❑ Yes ❑ No	❑ Yes ❑ No
Name of Subscriber		
Subscriber's Relationship to Patient		
Subscriber's Date of Birth (if other than patient)		
Subscriber's Social Security No. (if other than patient)		
Co-pay amount: (If not printed on card, contact your insurance to confirm)		
Identification No.		
Group No.		

EMERGENCY CONTACT INFORMATION:

In case of Emergency, who should be notified? _____ Relationship to patient: _____

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

The information provided is true to the best of my knowledge. I authorize treatment for myself or the above individual and I understand that I am ultimately responsible for charges associated with medical services and agree to pay all bills upon receipt of the statement, unless other arrangements are made. I authorize the physician to release to my Insurance and its agents any information required to process my insurance claims. I further agree that a copy of this agreement shall be as valid as the original. I authorize my insurance company to pay the provider directly.

Signature: _____ Today's Date: _____/_____/_____
(Patient or Responsible Party)