

PETER B. ODLAND, M.D.  
ANNALISA K. GORMAN, M.D.



**SKIN SURGERY CENTER**  
SKIN CANCER SPECIALISTS

SARAH B. PATTON, PA-C  
NICOLE M. MARSHALL, PA-C  
KATE Y. MAURER, PA-C

**PATIENT REGISTRATION:**

Name: \_\_\_\_\_  
Last First M.I.

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_\_ Sex:  Male  Female

Mailing Address: \_\_\_\_\_  
City State Zip

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

E-Mail: \_\_\_\_\_ Marital Status (optional): \_\_\_\_\_

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  
Phone: ( ) \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<b>Primary Insurance</b>	<b>Secondary Insurance</b>
Name of Insurance		
Insurance Through Employer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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: \_\_\_\_\_  
(Patient or Responsible Party)

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_