REGISTRATION DATA **Allison Jones Stocker, M.D., P.A. /// Skin by Design Dermatology & Laser Center, P.A**

********PRINT CLEARLY*** *****

Name_____Date_____Sex: M F
last **first** **middle**

Cell # (_____)_____

Address_____Zip_____Home # (_____)_____
City **State**

Age_____Date of Birth_____/_____/_____Social Security#_____/_____/_____Marital Status_____

MUST SUPPLY:

Occupation_____Your Employer_____

Work # (_____)_____Employer's Address_____

Driver's License #:_____

Only Blue Cross Insurance Information **MUST SUPPLY:**

Grp/policy#:_____**ID/Cert#:**_____**Subscribers date of birth:**_____/_____/_____

PLEASE SUPPLY EMAIL ADDRESS FOR APPOINTMENT CONFIRMATION AND PRACTICE UPDATES

EMAIL ADDRESS:_____

If Minor, Name of Parent/Guardian_____Relationship_____

MUST SUPPLY:

Insured's Employer_____Address_____Work # _____

In an emergency contact_____Phone_____Relationship_____

List medications and dosage which you are taking or take **regularly** (including over-the -counter herbal & vitamins)

_____Over

List **other** medications which you take **occasionally**: ❑See list - attached

_____Over

Allergies to medications_____

Check (√) the conditions which ***you*** have had:

____ Arthritis
____ Asthma/Allergies
____ Blood Clots (DVT)
____ Cancer (of which organ)_____
____ Diabetes
____ Glaucoma
____ Heart disease
____ Hepatitis Type _____
____ High Blood Pressure
____ HIV Infection
____ Tuberculosis
____ Skin Cancer
____ Skin Disease, please specify _____
Other_____

Check (√) the conditions which your ***blood relatives*** have had:____Asthma/Allergies

____Diabetes
____High Blood Pressure
____ Skin Cancer
____Skin Disease, please specify _____
Other_____

Family Physician name & #:_____Referred by_____

Please read & sign below:

1. I understand that I am responsible for payment of medical services provided by the physician(s)/Skin by Design and that my entire bill for medical services is due at completion of each individual appointment. **2. Also I understand that I am responsible for any unpaid balance my insurance company leaves upon receipt of notice.** ***3. I authorize this office to release any and all medical records pertaining to me for any diagnosis and treatment received today or subsequently to my medical doctor(s) and my insurance company(s).*** ***4. I agree that if I cancel any appointment I will give a 24 hour advance notice or there will be a $50-$100 fee for non-cancellation.***

X_____ ***REQUIRED:Driver's License & BlueCrossBlueShield PPO of Tx insurance card***

Signature(Patient/Guardian