HOLLAND Dermatology Barbara S. Drozdowski, MD FAAD

General Registration Form

Did your doctor refer you to our office? NO YES – Name Referring Doctor: ______________________________

How did you hear about us: Doctor____ Family/Friend____ Newspaper____ Internet____
Phone Book____ Radio____ School Ad____/ What School? ___________
Other_____/ Please List__________________

I have received the Notice of Privacy Practices from HOLLAND DERMATOLOGY and understand how my medical information may be used, disclosed and protected. ***Initial______Date____________***

Name____ Male or Female
First MI Last

Birth Date ____/____/____ Social Security #_________-_______-__________

Address____ Home Phone (____)____________________

City____________________State_______Zip_________ Cell Phone (____)____________________

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Work Phone (____)____________________

May we leave personal medical information on your answering machine/voice mail? YES or NO

In case of an emergency, who should be notified? ____

Relationship: ____________________________________ Phone #: (______)______________________

If you would like our office to be able to discuss your medical information with family members/friends you MUST provide their information below.

If no one is listed, our office will not be able to give ANY medical information to anyone other than the patient.

Name:________________________________Relationship:______________Phone #______________

Name:________________________________Relationship:______________Phone #______________

Name:________________________________Relationship:______________Phone #______________

Please provide any insurance cards to the receptionist & complete the following insurance information.

Primary – Insurance Company: Ins. Co. Name____
Name of Policy Holder (Insured):_________________________Holder's Date of Birth:____/____/____
Your relationship to Policy Holder (circle one) Self Spouse Dependent
Policy Holder's Social Security #: ________________________________

Secondary – Insurance Company: Ins. Co. Name____
Name of Policy Holder (Insured):_________________________Holder's Date of Birth:____/____/____
Your relationship to Policy Holder (circle one) Self Spouse Dependent
Policy Holder's Social Security #: ________________________________

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