HOLLAND Dermatology

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Patient Registration Form

Patient Name: _____ Birth Date: ____/____/____
First Middle Initial Last

Male or Female (circle)

Social Security # _____-_____-_____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Street Address: _____City:_____State:_____Zip:_____

Primary Phone Number: _____ Secondary Phone Number:_____

Emergency Contact Name: _____Phone Number: _____

- ☐ **I DO** authorize the physicians and employees of *Holland Dermatology* to **leave information** regarding appointment changes, laboratory results, biopsy results, or other diagnostic tests at the contact numbers/voicemail listed above.
- ☐ **I DO NOT** authorize the physicians and employees of *Holland Dermatology* to leave any information regarding appointment changes, laboratory results, biopsy results, or other diagnostic tests on my answering machine/voicemail.

Please circle whichever option applies for EACH of the *2 questions* below:

1. **Race:** Asian American Indian or Alaska Native African American
   Native Hawaiian Other Pacific Islander White Do Not Wish to Report
2. **Ethnicity:** Hispanic or Latino Not Hispanic or Latino Do Not Wish to Report

Primary Language: _____

Place of Birth: City:_____State:_____Zip:_____Country: _____

Employer's Name: _____

Occupation: _____**Industry:**_____

Please be aware that any biopsies performed in this facility will be subject to Pathology charges. If you have any concerns or questions related to this matter, please be sure to address them with the nurse or doctor, prior to the completion of a biopsy procedure.*

PLEASE NOTE: As a *courtesy*, we will attempt to call **ALL** of our patients prior to their upcoming appointments. However, in the event our staff is unable to reach you, we still expect all patients to make their scheduled appointments on time or call ahead to cancel.

By signing below you are stating that you are aware of the Notice of Privacy Practices from Holland Dermatology and understand how my medical information may be used, disclosed and protected

PATIENT / GUARDIAN SIGNATURE: _____**DATE:** _____