06/29/23 sd

HOLLAND Dermatology

Patient Registration Form

Barbara S. Drozdowski, MD FAAD

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

☐Male ☐ Female Social Security # _____-_____-_____ **(Please provide if you have VA insurance)**

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Mailing Address _____City _____ State _____ Zip_____

Primary Phone Number _____ ☐ Cell ☐ Landline

Secondary Phone Number _____ ☐ Cell ☐ Landline

Email _____ Primary Care Physician _____

Emergency Contact _____ Phone Number _____

VOICEMAILS/MESSAGES (pick one):

☐ **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 laboratory results, biopsy results, or other diagnostic tests on my answering machine/voicemail.

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

Race: Asian American Indian/Alaska Native African American Native Hawaiian Other Pacific Islander White Do Not Wish to Report

Ethnicity: Hispanic or Latino Not Hispanic or Latino Do Not Wish to Report ---------- Primary Language: _____

If patient is NOT the subscriber, please fill out subscriber name and birthdate below.

Primary Insurance _____ ID # / Group # _____/_____

Subscriber Name _____ **Date of Birth** _____

Secondary Insurance _____ ID # / Group # _____/_____

Subscriber Name _____ **Date of Birth** _____

Please be aware that biopsies performed in this facility will be subject to Pathology charges. If you have 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, ALL of our patients are notified of upcoming appointments in our office via automated phone call, text message, and/or email. **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**

Signature of Patient _____ **Date** _____/_____/_____
(Legal Guardian if Patient is a Minor)

IF THIS FORM HAS BEEN COMPLETED PREVIOUSLY – Please review/update and **Initial** _____ **Date** _____