Knoxville Center for Dermatology & Plastic Surgery

Initial Patient Registration

Patient Full Name: _____
Date of Birth: _____ Sex: _____ SSN: _____
Employer: _____ Employer Phone:_____

Who is your Primary Care Physician? _____ _____
Name Address
Referring Physician if not PCP? _____ _____
Name Address
How did you hear about us? _____
Pharmacy: _____ _____ _____
Name Address Phone
Emergency Contact: _____ _____ _____
Name Phone Relationship
Minor Patients Under Age 18:
Responsible Party Full Name: _____
Responsible Party DOB: _____ Sex: _____ SSN: _____

If not the primary insured:
Insured Party Name: _____ DOB: _____
Address: _____
Sex: _____ SSN: _____
Employer: _____

I authorize The Knoxville Center for Dermatology and Plastic Surgery to speak to and share information regarding matters of my health, lab results & appointments with the following person(s):
name _____ relationship _____
name _____ relationship _____
name _____ relationship _____
( ) I do NOT want to share my information with anyone.

Tell us how we may contact you (**check all that apply**)
( ) Home number _____ ( ) Leave a message for appointment date & time
( ) Cell phone number_____ ( ) Leave a message with normal test results
( ) Work number _____ ( ) **DO NOT** leave a message

Please Initial the Following:
_____ I authorize my insurance benefits be paid directly to the physician.
_____ I understand that I am financially responsible for any balance.
_____ I also authorize KCDPS or my insurance company to release any information required to process my claims. The above information is accurate to the best of my knowledge.

_____ _____
Signature of Patient/Patient Representative Date