



NEW PATIENT REGISTRATION (MINOR)

PATIENT INFORMATION

Last Name: _____

Preferred Telephone: _____

First Name: _____ Middle Initial: _____

May we leave a detailed message? YES NO

Address1: _____

Email Address: _____

Address2: _____

Birthdate: _____ (MM/DD/YYYY)

City: _____ State: _____

Birth Sex: male female

Zip Code: _____ Country: _____

Gender Identity: unspecified male female

transgender genderqueer other

Primary Care Physician: _____

Preferred Language: _____

Primary Care Phone Number: _____

Referring Physician: _____

Race: White American Indian Asian Other Black or African American Native Hawaiian

Ethnic Group: Hispanic or Latino Not Hispanic or Latino Decline

PARENT OR GUARDIAN INFORMATION

Father; First & Last Name: _____

Telephone: _____

Mother; First & Last Name: _____

Telephone: _____

Guardian; First & Last Name: _____

Telephone: _____

ACCOUNT INFORMATION - please provide responsible party billing information below:

Name: _____

Preferred Telephone: _____

Address1: _____

Birthdate: _____ (MM/DD/YYYY)

Address2: _____

May we leave a detailed message? YES NO

City: _____ State: _____

Birth Sex: male female

Zip Code: _____ Country: _____

YES, I have insurance & will bring my card to my appointments. ** We will require your insurance card(s) to be uploaded prior to your appointment or scanned in upon your arrival

NO, I do not have insurance and will be paying out of pocket for my dependent's appointments.

For your protection, and in compliance with Federal Regulatory Requirements to safeguard against identity theft you will be required to provide us with a valid photo ID with your current address and your insurance card **every visit. We will scan this into our system in order to verify your identity in respect to any requests for your medical information and submitting of information to your insurance carrier for payment. I authorize West Michigan Dermatology to file a claim with my insurance carrier for services rendered.

I accept financial responsibility for any non-covered or denied charges and for co-pays, deductibles and coinsurance. Should my account ever become delinquent and an outside agency is used for collection, I understand an appropriate collection fee may be assessed.

Patient or authorized representative signature

date

GRANDVILLE

3434 RIVERTOWN POINT CT. SW
GRANDVILLE, MI 49418
[P] 616.257.3344 [F] 616.257.1491

HOLLAND

3290 N. WELLNESS DRIVE, BLDG. D., SUITE 240
HOLLAND, MI 49424
[P] 616.395.9379 [F] 616.820.1457

ROCKFORD

6150 NORTHLAND DRIVE
ROCKFORD MI 49341
[P] 616.942.9343 [F] 616.942.2538