BONITA DERMATOLOGY, PA
REGISTRATION FORM
(Please Print)

Today's date:	Email:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Employer:	Occupation:	Race:	Birth date: / /	Age:	Sex: ❑ M ❑ F
Years at Occupation and/or Years Retired:	Employer Phone Number: ( )	Cell Phone Number: ( )	Home Phone Number: ( )		

Primary Street address (Local):	City:	State:	ZIP Code:
Secondary Street Address:	City:	State:	Zip Code:

You chose Bonita Dermatology because (please check one box):	❑Dr.	❑ Insurance Plan	❑ Website

❑ Family	❑ Friend	❑ Close to home/work	❑ Yellow Pages	❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please only complete if you did not give your insurance card to the receptionist.)

Person Responsible for Bill:	Date of Birth: / /	Address (if different):	Home Phone Number: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer Address:	Employer Phone Number: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please Indicate Primary Insurance	❑ MEDICARE	❑ BCBS	❑UHC	❑ AETNA	❑ CIGNA
❑ CHP	❑ HIGH DED with HSA	❑TRICARE	❑HUMANA	❑ Other:	

Subscriber's Name and SS #:	Age:	Date of Birth: / /	Group Number:	Policy Number:	Co-Payment: $

Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

Name of Secondary Insurance (if applicable):	Subscriber's Name:	Group Number:	Policy Number:

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at the same address):	Relationship to Patient:	Home Phone Number: ( )	Work Phone Number: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Bonita Dermatology, PA and the insurance company to release any information required to process my claims.

Patient/Guardian Signature: *Date:*