Jeffrey D. Case, MD • Gretchen McCabe, APRN

Dermatology & Skin Surgery Clinic

110 Medical Center Drive, Paducah KY 42003
(270) 443-2471 skinsurgeryclinic.com

PATIENT REGISTRATION FORM

Please Fill Out Completely

PATIENT INFORMATION

Date _____

Patient Name _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell _____ Email Address _____

Birth Date _____ Age _____ Social Security No. _____

Employer _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Sex ☐ Male ☐ Female

Spouse's Name _____

Spouse's Employer _____

Primary Care Physician _____ Phone _____

If referred by physician, give name, address & phone number of referring physician:

Emergency Contact (not in same house)

Name _____

Home Phone _____ Work Phone _____

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PATIENT REGISTRATION FORM

Please Fill Out Completely

INSURED CARDHOLDER OR OTHER FINANCIALLY RESPONSIBLE PARTY

(If not patient – please complete; if patient – simply write "Patient" in the space provided for name)

Name _____ Street Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Birth Date _____ Social Security No. _____

Employer _____ Employer address _____

Relationship to Insured (husband/wife/son/daughter/self) _____

INSURANCE INFORMATION

(Including Governmental, such as Medicare, Medicaid, CHAMPUS, etc.) – Please present your Insurance Card(s) for copying.

Primary Insurance

Insurance Company _____

Secondary Insurance

Insurance Company _____

I hereby authorize the release of any medical information necessary to process this claim which has been acquired in the course of my treatment or care. I also authorize payment directly to the physician of the medical/surgical benefits.

Signed _____ Date _____

ATTENTION MEDICARE PATIENTS

I authorize release of any medical information necessary to process my claim to my Medigap Insurer, and I authorize payment directly to the physician.

Signed _____ Date _____