

**Albemarle Dermatology Associates, LLC**  
**3350 Berkmar Drive • Charlottesville, Virginia 22901**  
**(434) 923-4651 FAX (434) 964-3636**

**PATIENT REGISTRATION**

**Patient's Full Name** \_\_\_\_\_  
Last Name First Name Middle Initial

**SEX** M F

**Social Security Number** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

**Your Mailing/Billing Address**

Street City State Zip Code

**Home Phone** \_\_\_\_\_ **Work Phone** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

**Patient's Occupation** \_\_\_\_\_ **Employer** \_\_\_\_\_

**Marital Status** M W S D

**If Married, Spouse Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
**Spouse Employer and Work Number** \_\_\_\_\_

**Referred by** \_\_\_\_\_ **Primary MD** \_\_\_\_\_

**Insurance #1** \_\_\_\_\_ **Subscriber** \_\_\_\_\_ **Relationship** \_\_\_\_\_  
\*\*\* **Subscriber Date of Birth** \_\_\_\_\_  
**#2** \_\_\_\_\_ **Subscriber** \_\_\_\_\_ **Relationship** \_\_\_\_\_  
\*\*\* **Subscriber Date of Birth** \_\_\_\_\_

**Emergency Contact** \_\_\_\_\_  
Name Phone Number

**For Minors: Responsible Party:** \_\_\_\_\_  
Name Relationship Social Security Number  
Is address and phone number the same as above? Yes or No If no, please complete below

\*\* I authorize Albemarle Dermatology Associates to release any medical or other information necessary to process this claim and any future claims. I authorize payment of medical benefits to the provider for services rendered. I also request payment of government benefits either to myself or to the party who accepts assignment.

\*\* I understand that I am financially responsible for all charges not paid by insurance. I understand if my account becomes assigned to a collection agency, that I am responsible to pay the collection agency fee, court cost and attorney fees.

**\*\*Your copay is expected at the time of service.** If you do not pay on the day of your appointment a \$10.00 billing fee will be added to your account.\*\*

**\*\*Do we have your permission to:**

- Leave a message on your home answering machine  Yes  No
- Leave a message on your work voice mail?  Yes  No
- Discuss your medical condition with any member of your household?  Yes  No  
If yes, whom: \_\_\_\_\_ Relationship: \_\_\_\_\_
- If patient is a minor, information can be discussed with:  Mother  Father  Step-Mother  
 Step-father  Grandmother  Grandfather

**\*\*Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
Patient or Legal Guardian