



Albemarle Dermatology Associates
3350 Berkmar Drive
Charlottesville, VA 22901
Phone: (434) 923-4651
FAX: (434) 964-3636
www.albemarledermatology.com

Patient Registration

BASIC INFORMATION

Name _____
Last First MI

Address _____
City State Zip

Date of Birth _____ Gender: M F Marital Status: S M D W

Home Phone (____) _____ Cell Phone (____) _____

Work Phone (____) _____ Email: _____

Occupation _____ Employer _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Address _____
City State Zip

Phone (____) _____

INSURANCE INFORMATION

Name of Primary Insurance _____
Subscriber's Name _____ DOB _____
Relationship to Patient _____

Name of Secondary Insurance _____
Subscriber's Name _____ DOB _____
Relationship to Patient _____

For Minors: Responsible Party
Name _____ Relationship _____
Address and phone number, if different from above:

CONSENT FOR COMMUNICATION

May we leave a message on your home answering machine? Yes No
May we leave a message on your cell phone voice mail? Yes No
May we leave a message on your work voice mail? Yes No
May we leave a message with any member of your house? Yes No
If yes, please specify: Name _____ Relationship _____
May we discuss your medical condition with a member of your household? Yes No
If yes, please specify: Name _____ Relationship _____

Patient Signature (if minor, Parent/Guardian Signature)

Date _____