ESSEX DERMATOLOGY

20 Saybrook Rd
Essex, CT 06426
(860) 767-9998

Patient Registration

Last Name _____ First Name _____ SSN _____ Date of Birth _____

Home Phone # _____ Work Phone # _____ Mobile Phone # _____ Preferred Phone _____

Ok to leave a detailed message? □Yes □No

Street Address _____ City _____ State _____ Zip Code _____

Email Address _____ □ I do not have an email address

Sex: □Male □Female **Language**: □English □Other_____

Race: □ Decline □American Indian or Alaska Native □Asian □Black or African American □Native Hawaiian or other Pacific Islander □White

Ethnicity: □Decline □Hispanic or Latino □Not Hispanic or Latino

Emergency Contact: Full Name _____ Phone # _____ Relation _____

INSURANCE

Insurance Company: _____ Address: _____

Policy #: _____ Group #: _____

Policy holder name: _____ Policy holder date of birth: _____

Authorizations

1. I consent to any and all health care treatment and diagnostic procedures provided by Essex Dermatology, LLC and its associated physicians and personnel.
2. I consent for the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with Essex Dermatology, LLC Notice of Privacy Practices.
3. I authorize payment of medical benefits to Essex Dermatology, LLC or their designee for services rendered.
4. A copy of the Notice of Privacy Practices will be provided to me in the office for review at my request.

Patient/Authorized Person's Signature: _____ **Date**: _____