SOLANO DERMATOLOGY ASSOCIATES
2290 SACRAMENTO STREET VALLEJO, CA 94590
PHONE: (707) 643-5785 AND FAX: (707) 643-5876

PATIENT REGISTRATION FORM - * **PLEASE COMPLETE THE ENTIRE FORM** *

Account#: Today's Date: / /

1. Patient Information

Name_____

Mailing Address_____

City, State, ZC_____

Home Phone_____ Work Phone_____ Other Phone_____

Date of Birth___/____/___ Age___ Sex M / F Marital Status S / M / D / W SS#_____

Occupation_____ Spouse's Name_____

Emergency Contact_____ Phone Number_____

2. Employment Information

Employer Name_____ Employer Phone_____

Employer Address_____

City, State, ZC_____

3. Parent or Responsible Party (if different from patient)

Name_____

Mailing Address_____

City, State, ZC_____

Home Phone_____ Work Phone_____ SS#_____ DOB _____

4. Insurance/Payment Information - (Please complete.)

If Patient is Self-Pay, please check the box, otherwise list the information requested below. ☐
All Self-Paying patients are required to pay at time of service.

*Primary Ins Name*_____ *Secondary Ins Name*_____

*Ins Address*_____ *Ins Address*_____

_____ _____

*Name of Insured*_____ *Name of Insured*_____

*Insured's ID#*_____ *DOB*_____ *Insured's ID#*_____

*Group#*_____ *Group#*_____

*Relationship to patient*_____ *Relationship to patient*_____

Pharmacy of Choice_____ Phone Number_____

Primary Care Physician_____ Referred By_____

Update with Date Stamp & Pt Initials:

Please sign stating that all the correct information has been given completely: _____
Patient/ Responsible Party Signature