Gregory M. Bricca, M. D., Inc. & California Skin Surgery Center, Inc

Patient Registration Form (Please print in **Black Ink** and fill out completely) (Write "N/A" where applicable)

Legal Name - Last _____ First _____MI ____

Mailing Address _____

City _____ State ____ Zip _____

Phone Home ( ) _____ Cell ( ) _____ Work ( ) _____

Date of Birth ____/____/____ Age _____ Sex M / F Marital Status S / M / D / W

Pharmacy Name/Address/Phone:_____

Employer _____ Occupation _____

Spouse/Parent Name _____ Phone _____

Emergency Contact _____ Phone ( ) _____

Relationship _____ Address _____ City _____ State ____

Do you have a health care power of attorney? Yes / No If yes, please provide documentation.

May we leave biopsy results/personal information on your answering machine? Yes / No

I authorize Dr. Bricca or his office staff to discuss my health care information with the following family members or other individual/s (please be specific):

Name/s: _____ phone: ( ) _____

Name/s: _____ phone: ( ) _____

Referred by: Physician Name _____ Specialty _____

Friend/Family Name _____

Other (How did you hear about us?) _____

Please list other family members who are patients with us: _____

Primary Care Physician: _____(if same as above check here _____)

Address: _____City, State, Zip: _____

Insurance Information:

Primary Insurance Company _____ ID#_____ Group # _____

Policy Holder's Name & Date of Birth _____

Secondary Insurance Company _____ ID#_____ Group # _____

Policy Holder's Name & Date of Birth _____

I authorize the release of medical information to and from my primary care and referring physician(s), outside laboratories or consultants, if needed, in the course of my examination and treatment and as necessary to process insurance claims, insurance applications and prescriptions until revoked in writing. I also authorize payment of medical benefits to Gregory M. Bricca, M.D., Inc. and California Skin Surgery Center, Inc. I am aware that the Notice of Privacy Practices and Patient Rights and Responsibilities are available for me to review at anytime.

Patient or Responsible Party Signature _____ Date ____/____/_____