

**Dermatology Associates of Lancaster, LTD.
Patient Enrollment**

PLEASE PRINT

DATE: _____

LAST NAME: _____

FIRST NAME: _____ MIDDLE INITIAL: _____

BIRTHDATE: _____ MARITAL STATUS: S M D W

ADDRESS: _____

CITY: _____ STATE: _____

ZIP CODE: _____

HOME PHONE #: _____ WORK PHONE #: _____

CELL PHONE #: _____

SOCIAL SECURITY #: _____

EMPLOYER: _____

EMPLOYER ADDRESS: _____

PATIENT'S OCCUPATION: _____

REFERRING DOCTOR: _____

FAMILY MEMBERS THAT HAVE BEEN PATIENTS HERE: _____

EMERGENCY CONTACT:

NAME: _____

PHONE #: _____

RESPONSIBLE PARTY:

NAME: _____

PHONE #: _____

PRIMARY INSURANCE COVERAGE INFORMATION:

INSURANCE CARRIER: _____

CLAIMS ADDRESS: _____

SUBSCRIBER: _____

LAST NAME

FIRST NAME

(MI)

SUBSCRIBER'S ADDRESS (if different from patient): _____

SUBSCRIBER'S DATE OF BIRTH: _____

SUBSCRIBER'S SOCIAL SECURITY #: _____

SUBSCRIBER'S RELATIONSHIP TO PATIENT: _____

POLICY #: _____ GROUP #: _____

PRIMARY CARE PHYSICIAN IF REQUIRED BY INSURANCE: _____

SECONDARY INSURANCE COVERAGE INFORMATION:

INSURANCE CARRIER: _____

CLAIMS ADDRESS: _____

SUBSCRIBER: _____

LAST NAME

FIRST NAME

(MI)

SUBSCRIBER'S ADDRESS (if different from patient): _____

SUBSCRIBER'S DATE OF BIRTH: _____

SUBSCRIBER'S SOCIAL SECURITY #: _____

SUBSCRIBER'S RELATIONSHIP TO PATIENT: _____

POLICY #: _____ GROUP #: _____

PRIMARY CARE PHYSICIAN IF REQUIRED BY INSURANCE: _____