GEORGETOWN
DERMATOLOGISTS, P.C.

Michael S. Frank, MD
Christopher J. Remishofsky, MD
Jennifer Schaeff, PA-C, MMS

REGISTRATION INFORMATION ***Please print*** Today's Date: _____

Mr. Mrs. Ms. Dr. _____ _____ _____
Last name First name Middle name

Date of birth: _____/_____/_____ Age _____ Sex: M F Social Security #: _____

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____ _____
Home Phone # Alternate Phone # (mobile) E-mail address (optional)

_____ _____
Patient Employer Business Phone #

_____ _____/_____/_____ _____ _____
Responsible Party **(if different from above)** Date of Birth Social Security # Telephone #

_____ _____
Responsible Party's Employer Business Phone #

_____
Name of Spouse/Guardian

How did you learn about our office?
[ ] Referred by physician
Physician's name: _____
[ ] Internet
[ ] Family member
[ ] Friend
[ ] Insurance company

Name of Primary Care Physician: _____

Names of other family members seen in our office: _____

INSURANCE & PAYMENT INFORMATION

_____ _____ _____ _____/_____/_____
Name of insurance carrier Group/Policy # Contract/ID # Subscriber's Date of Birth

Do you have a Health Savings Account (HSA/HRA) that you would like to use? [ ] Yes [ ] No

For all patients less than 18 years of age, a parent or guardian must sign:

I give my permission for Michael S. Frank, MD, Christopher J. Remishofsky, MD, and/or Jennifer L. Schaeff, PA-C, to examine and treat my child or dependent.

Parent/Guardian: _____

ALL PATIENTS: Please read and sign reverse side.
Please give your insurance card, photo ID, and any referral forms to the receptionist before the doctor examines you.