



TONI C. STOCKTON, MD, FAAD, PLLC

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PATIENT REGISTRATION

Date: _____ Please circle: **NEW** or **UPDATED** ****Please PRINT and COMPLETE using BLACK INK only****

LAST Name: _____ **FIRST** Name: _____ Middle Initial: ___ **DOB**: _____ **Age**: _____ **Sex**: _____

Race: _____ **SSN**: _____ - _____ - _____ **Marital Status**: Married / Divorced / Widowed / Single

Address: _____ **City**: _____ **State**: _____ **ZIP**: _____

Alternate Address: _____ **City**: _____ **State**: _____ **ZIP**: _____

Primary Phone for Contact: (_____) _____ - _____ **Cell/Other Phone**: (_____) _____ - _____

Emergency Contact Name: _____ **Emergency Contact Phone**: (_____) _____ - _____

Email Address: _____ **Occupation**: _____

Primary Care Physician: _____ **Primary Care Physician Phone**: (_____) _____ - _____

Referring Physician: _____ **Referring Physician Phone**: (_____) _____ - _____

Preferred Pharmacy: _____ **Pharmacy Phone Number** (_____) _____ - _____

Dermatology Brand-Name medications are often more effective than Generic medications.

Do you prefer? Brand-Name Usually Generic Meds if Equally Effective Generic Meds Even if Less Effective to Save Cost

Primary Insurance Company: _____ **Policy Holder Name**: _____

Relationship to Patient: _____ **Policy Holder SSN**: _____ - _____ - _____ **DOB**: ____ / ____ / ____

Insurance ID#: _____ **Employer**: _____

Secondary Insurance Company: _____ **Policy Holder Name**: _____

Relationship to Patient: _____ **Policy Holder SSN**: _____ - _____ - _____ **DOB**: ____ / ____ / ____

Insurance ID#: _____ **Employer**: _____

PLEASE NOTE: All required referrals must be coordinated by the PCP and faxed prior to or presented at the time of the appointment

Our office uses a HIPAA compliant automated system called CallPointe to remind you of upcoming appointments and the availability of laboratory results and/or reports.

Health Portability and Accountability Act of 1996 (HIPAA) also includes protected health information.

Signing below signifies that you have had the opportunity to view and/or receive explanation of the privacy notice. You may request a copy or read a copy located in the waiting room.

Printed Name _____ **Patient Signature** _____ **Date** _____

Witness _____ **Date** _____

You authorize sharing of your Personal Health Information (PHI) with someone else? No Yes *If Yes, who? _____

Aesthetic services and cosmetic procedures that our office provides:

•Restylane® •Juvederm® •Perlane® •Botox® •Dysport™ •Intense Pulsed Light •Spider Vein Therapy •Facials •Chemical Peels •Microdermabrasion •Procedures for Wrinkles, Sun Damage, Skin Tightening, Dark Spots, Unwanted Hair or Acne

Would you like to schedule a consultation with an aesthetician at a later date? Yes No

Would you like to receive email notifications regarding monthly treatment and skin care specials? Yes No

How did you hear about Stockton Dermatology?

___ Friend ___ Facebook ___ Twitter ___ Our Website ___ Newspaper ___ Yellow Pages ___ Other _____

*****FOR OFFICE USE ONLY BELOW*****FOR OFFICE USE ONLY BELOW*****

MR #: _____ **Call Pointe ID #**: _____ **Provider**: _____