LEWIS H. KAMINESTER, M.D., F.A.C.P.
Dermatology
840 U.S Highway Number One, Suite 300
North Palm Beach, Florida 33408
(561) 626-7546
www.dermatologypalmbeach.com

NEW PATIENT REGISTRATION

Diplomate, American Board of Dermatology
Fellow, American Academy of Dermatology
Fellow, American College of Physicians

PLEASE PRINT

PATIENT INFORMATION

LAST NAME	FIRST	MI	DATE	PATIENT AGE

LOCAL ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE
				( ) -
SECOND ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE
				( ) -

SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX	IS RESPONSIBLE PARTY THE PATIENT?	CELL PHONE
	/ /		☐ YES ☐ NO	( ) -

EMPLOYED BY / SCHOOL	YEARS	ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE
						( ) -

TYPE OF WORK

EMAIL

PLEASE SPECIFY THE RACE YOU MOST CLOSELY IDENTIFY WITH	LANGUAGE SPOKEN	DO YOU CONSIDER YOURSELF TO BE ETHNICALLY HISPANIC OR LATINO? ☐ YES ☐ NO

REFERRED BY: ☐ INSURANCE COMP. ☐ BY DOCTOR ☐ FRIEND ☐ YELLOW PAGES ☐ INTERNET ☐ OTHER

LAST NAME	FIRST	MI	ADDRESS	TELEPHONE
				( ) -

NEAREST RELATIVE NOT LIVING WITH YOU

LAST NAME	FIRST	MI	ADDRESS	TELEPHONE
				( ) -

FAMILY PHYSICIAN

LAST NAME	FIRST	MI	ADDRESS	TELEPHONE
				( ) -

PRIMARY INSURED INFORMATION

LAST NAME	FIRST	MI	DATE OF BIRTH	SEX	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER
			/ /			- -

EMPLOYED BY	HOME TELEPHONE	ADDRESS OF EMPLOYER	TELEPHONE
	( ) -		( ) -

AS THE RESPONSIBLE PARTY, I AGREE THAT ALL CHARGES THAT ARE NOT DIRECTLY PAID BY MY INSURANCE COMPANY WILL BE MY RESPONSIBILITY.

RESPONSIBLE PARTY SIGNATURE	TODAY'S DATE
X	/ /

REASON FOR TODAY'S VISIT - OR - CHIEF COMPLAINT? WHAT PARTS OF THE BODY ARE INVOLVED? WHAT IS THE DURATION OF THIS PROBLEM?

PAYMENT OF BENEFITS

I authorize payment of benefits, as determined by the Company, directly to:

Surgeon / Physician ☐ Yes ☐ No

I understand that unless I have checked "Yes" above, benefit payments will be paid to me. I also understand that even if I have checked "Yes" above, I may still be responsible for any amounts not paid by my Insurance Company in the event that the charges made are not reasonable and customary.

X	DATE
	/ /

MEDICAL RELEASE AUTHORIZATION

Insured party must sign for all claims. Dependent patient must also sign if not a minor. I authorize any insurance company, organization, employer, hospital physician, dentist, or pharmacist to release any information requested with regard to processing my claim.

I certify that the information I furnish is true and correct. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

X	DATE
	/ /