JENNIFER W. PENNOYER, M.D.
Medical & Surgical Dermatology
Laser & Cosmetic Skin Care

PATIENT REGISTRATION AND HIPAA FORM

Patient Name (Last, First, Middle Initial)		Date of Birth
Mailing Address (City, State, Zip)		
Birth Sex	Sexual Orientation & Gender Identity	Race
Pharmacy Name & Address		Marital Status
Email Address. Can we email you? YES NO		Employer
Primary Care Physician & Address		
Emergency Contact Name/Phone #/Relationship		
Are you the insurance policy holder? If no, please indicate name/date of birth/relation to holder.		
Authorized people to receive information regarding your treatment (spouse, parent, partner, sibling, etc)		

How may we contact you? (Please write in number)

Home phone_____ **Cell Phone**_____

_____ DO NOT leave a message **_____ DO NOT leave a message**

_____OK to leave a message **_____OK to leave a message**

_____Use as primary number **_____Use as primary number**

Patient's Signature:_____ Today's Date:_____

Parent/Guardian's Name & Signature:_____

My above signature acknowledges that I have been provided the Insurance Authorization and Assignment, Acknowledgement of Notice of Privacy Practices and Health Insurance Portability and Accountability Act of 1998
(located on the clipboard)