MID-COUNTY
DERMATOLOGY

Patient Registration Information
3009 N. Ballas Road, Building B, Suite 100
St. Louis, MO 63131
314-994-0200

Last Name _____ First Name _____ MI _____

Date of Birth _____ Age _____Sex _____

Street Address_____ City _____

State _____ Zip Code _____ Email _____

Phone (H) _____ Phone (C) _____

Employer _____ Occupation _____

Preferred Pharmacy Name _____ Pharmacy Number _____

Primary Care Physician _____ Phone Number _____

Responsible Party (if younger than 18 years of age)

Name _____ Relationship _____ Phone Number_____

Full Address _____

DOB _____

AUTHORIZATION/WAIVER OF BENEFITS
I hereby authorize the release of any information necessary to complete and process my insurance claims. I understand that it is my responsibility to obtain all necessary referrals from my PCP prior to my visit. If services are denied due to lack of referral, I am responsible for payment in full. I also understand that I am responsible for payment of my account in full or for the portion not covered by my insurance. Finally, I understand that I will be responsible for 100% of all cosmetic charges incurred in this office.

Print Name: _____ Date: _____

Signature: _____ Date: _____