Patient Registration Form

Aurora Clinic /ND Center for Dermatology
1451, 44th Ave. South, Unit F, Grand Forks, ND 58201
Phone 701-732-2700 or 1-888-732-2740 **Fax** 701-732-2701

Name:_____
First Middle Last

____ Married ____ Single Date of Birth _____/ _____/ _____

Spouse Name: _____ Spouse's Date of Birth: ____ / _____/ _____

Address:_____
Street Street Name Apt.# PO Box (if any)

_____
City State Zip

Phone: _____ (we will use this number to remind you of upcoming appointments)

Work Phone: _____Cell Phone_____

Email address _____
(Your e-mail will only be used if your provider is unable to contact you by phone. Your e-mail won't be used for solicitation.)

Social Security Number: _____ Sex: ☐ M ☐ F

Who Referred You? _____ **Primary Dr. ?** _____

Employer: _____
Name Address

If student: ☐Full Time ☐Part Time Name of School: _____

Where should statements of your account be sent if different from above?

_____
Name: Address Apt.# City State Zip

Name of Insurance: (s)_____ Policy # (s) _____

Policy Owner if other than Patient _____ Date of Birth_____/_____/_____

Patient Relationship To Policy Owner : ☐ Spouse ☐ Self ☐ Child ☐ Other

Do we have your permission to:

Leave a message on your answering machine at home? ☐Yes ☐No
Leave a message at your place of employment? ☐Yes ☐No
If an emergency if we can not get a hold of you who can we call? ☐Yes ☐No
If yes, whom: _____ Relationship _____
Is there any person other than yourself that we may discuss your medical care with ☐Yes ☐No
If yes, whom: _____ Relationship _____

_____ _____
Patient Signature Date