Hamilton Dermatology
Patient Registration

PATIENT INFORMATION

Full Name _____ Preferred Name _____

Date of Birth (mm/dd/yyyy) _____ Birth Sex ◯ Male ◯ Female

Preferred Pronouns ☐ She, Her, Hers ☐ He, Him, His ☐ They, Them, Their

Preferred Language _____

Race _____ Ethnic Group ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street Address _____ City _____ State ____ Zip _____

Email Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred Method for Communication: ☐ Patient Portal ☐ Home ☐ Mobile ☐ Work ☐ Email

Employer _____ Occupation _____

Employer Address _____ Employer Phone Number _____

EMERGENCY CONTACT

Name _____ Phone Number _____ Date of Birth _____

Address _____ Relationship _____

RESPONSIBLE PERSON *(IF DIFFERENT FROM PATIENT)*

Name _____ Phone Number _____ Relationship _____

Street Address _____ City _____ State ____ Zip _____

Phone Number _____ Date of Birth _____

Employer _____ Occupation _____

Employer Address _____ Employer Phone Number _____

INSURANCE INFORMATION

Name of Policy Holder _____ Date of Birth _____ Relationship _____

Insurance Company _____ Plan Name _____

Policy Number _____ Group Number _____

Claims Address _____ Customer Service Number _____

Tiffani K. Hamilton, MD
Madison Hamilton, PA-C

11800 Atlantis Place
Alpharetta, GA 30022
770-360-8881 / www.hamiltonderm.com

Preferred Contact Method

Name: _____ **Date of Birth:** _____

How do you wish to be contacted by our office? (please select all that apply)

☐ I request to be contacted regarding my treatment via the Modernizing Medicine EMA secure patient portal.

☐ I request to be contacted regarding my treatment via text message or cell phone.**

My preferred cell phone number is: _____

☐ I request to be contacted regarding my treatment via email.**

My preferred email address is: _____

☐ I request to be contacted regarding my treatment by phone. I understand that messages regarding my treatment will be left at this number should I be unavailable to answer the call.

My preferred phone number is: _____ ☐ home ☐ work ☐ cell

** I understand that text messages and email sent outside the patient portal are NOT secure forms of communication. **I will NOT hold Hamilton Dermatology liable for any accidental disclosure of protected health information through these forms of communication.**

I authorize you to discuss my care and treatment with the following individual(s):

_____ relationship: _____

_____ relationship: _____

_____ _____

Signature of Patient or Responsible Party Date