Aloha Dermatology, LLC
Patient Registration

Name ____ Preferred Name______________
First M Last

Date of Birth: ____/____/______ Age: _____ Sex: Male Female

Mailing Address ____
Street City State Zip

Home Phone: ( )________________ Work Phone: ( )_____________________

Cell Phone: ( )_________________ E-mail: ______________________________

Primary Care Physician: ___________________ How did you find us _______________

Pharmacy: ____________________________

RESPONSIBLE PARTY *(if different than patient) or EMERGENCY CONTACT:*

Name: ____ Date of Birth: ____/____/____
First M Last

Mailing Address:____
Street City State Zip

Home Phone: ( )_________________ Work Phone: ( )____________________

- May we leave appointment information on your phone messaging system(s)?

Home phone: Yes No Cell phone: Yes No Work phone: Yes No

- May we:

- May we:	**E-mail you appointment reminders?**	**Yes**	**No**
	Send you newsletters and special offers?	**Yes**	**No**
	Email you newsletters and special offers?	**Yes**	**No**

We will never share or sell your contact information with outside sources

- May we discuss your medical information with family members? **Yes** **No**

If **Yes**, please provide their names and relationship to you.

Name: ________________________________ **Relationship:**_______________

RECEIPT OF NOTICE OF PRIVACY PRACTICES: My signature below indicates I have received and/or reviewed a copy of my physician's: Notice of Privacy Practices (HIPPA regulations).

____ _______________

Signature of Patient or Responsible Party **Date**