2617 Sheffield Drive
Blacksburg, VA 24060
(540) 953-2210

306 West Main Street
Radford, VA 24141
(540) 731-6892

1225 Maple Avenue SW
Roanoke, VA 24016
(540) 953-2210

146 West Main Street
Wytheville, VA 24382
(276) 335-2112

PATIENT REGISTRATION

Patient Name: First_____MI_____Last_____

☐ Male ☐ Female Date of Birth_____ Social Security Number_____

Billing Address_____ City_____State_____Zip_____

Home Address_____ City_____State_____ Zip_____

Preferred Contact Phone Number home: _____ Preferred Contact Phone Number Cell:_____

Preferred Method of Confirming Appointments: ☐ Call or ☐ Text

Pharmacy_____ Location_____ Personal Email _____

Primary Care Physician_____ Practice Name_____

Employer_____ Work Phone_____Ext._____

Emergency Contact_____Relationship_____Primary Phone _____

PRIMARY INSURANCE & SUBSCRIBER INFORMATION

Primary Insurance_____ID#_____Group #_____

If Self, continue to next section Subscriber Information: ☐ Self ☐ Spouse ☐ Parent ☐ Male ☐ Female

Subscriber Name_____ Subscriber Date of Birth_____

Billing Address_____ City_____State_____Zip_____

Home Phone_____ Social Security Number_____

Cell Phone_____ Email Address_____

Employer_____ Work Phone_____Ext._____

Employer Address_____

SECONDARY INSURANCE INFORMATION

Secondary Insurance_____ ID#_____Group#_____

↳ Subscriber Name_____ Date of Birth_____

AUTHORIZATION FOR RELEASE OF INFORMATION
ASSIGNMENT OF INSURANCE BENEFITS AND PROMISE OF PAYMENT

Authorization is hereby given to release to my insurance company(s) such information that may be necessary for the completion of my clinic insurance claims. I understand I am financially responsible for charges not covered by insurance and assign any insurance benefits to New River Dermatology.

Patient or Parent/Guardian Signature_____**Date**_____