GOLDEN
DERMATOLOGY

2226 Liliha Street Suite 302
Honolulu, HI 96817

Patient Registration Form

Patient Name: _____ Date of Birth: _____Gender: ☐ M ☐ F
Last First MI

Email: _____ Marital Status: _____

Primary Address: _____
Street Number Street Name Apt City State Zip Code

Billing Address: _____
Street Number Street Name Apt City State Zip Code

Home Phone: _____Work Phone: _____ Cell Phone: _____

Emergency Contact: _____ _____ _____
Name Relationship Phone #

Primary Care Physician: _____ Address: _____ Ph# _____

Referring Physician: _____ Address: _____ Ph# _____

PARENT/GUARDIAN OR RESPONSIBLE PARTY (If under 18 or if different than above)

Name: _____ Date of Birth: _____Gender: ☐ M ☐ F
Last First MI

Relationship to Patient: _____ SSN:_____ Email: _____

Primary Address: _____
Street Number Street Name Apt City State Zip Code

Home Phone: _____Work Phone: _____ Cell Phone: _____

INSURANCE INFORMATION: Please provide copy of insurance card and ID upon check-in. All copayments are due at time of service.

Primary Insurance: _____ Secondary Insurance: _____

Subscriber name: _____ Subscriber Name: _____

Relationship to patient: _____ Relationship to patient: _____

Subscriber Date of Birth: _____ Subscriber date of Birth: _____

Subscriber ID#: _____ Subscriber ID#: _____

Group Name #: _____ Group Name #: _____

My signature below indicates that this form is accurate and complete to the best of my knowledge. I hereby authorize the release of any medical information to my primary care physician, referring physician, and consultant physicians, if needed. I also authorize the release of any medical information necessary to process claims related to my care with Dr. Spring K. Golden and authorize my insurance benefits to be paid directly to Golden Dermatology LLC. I acknowledge that I am financially responsible for any unpaid balance.

_____ _____
Signature of Patient or Responsible Party Date