Messenger Dermatology
A DIVISION OF COMPASS HEALTH

Patient Registration

Welcome to Messenger Dermatology! Please complete each page and return your completed form to the front desk as soon as you're done. We are happy to answer any questions.

Personal Information

Date: ____/____/_____

Name:

_____

Marital Status:

◯ Married ◯ Single

◯ Widowed ◯ Divorced

Date of Birth:

____/____/_____

Gender:

◯ Male ◯ Female

Address: _____ **Apt/Unit:** _____

City: _____ **State:** _____ **Zip:** _____

Primary Phone:

( ) _____ ❑ Home ❑ Work ❑ Cell

Is it OK to leave a detailed message at this number? ❑ Yes ❑ No

Secondary Phone: ❑ Home ❑ Work ❑ Cell

( ) _____

Email Address: _____

Employment:

Employer: _____ Occupation:_____

Emergency Contact Information

Please provide an emergency contact along with authorization to share medical information with that person.

Name:	**Relationship:**	**Phone:**
_____	_____	**( ) _____**

Do we have your permission to share medical results/information with the contact listed above? ❑ Yes ❑ No

Preferred Pharmacy and Primary/Referring Doctor

Please provide the contact information for both your preferred pharmacy, as well as your primary care doctor and referring doctor.

Primary Care Doctor: _____

Referring Doctor: _____

Preferred Pharmacy: (Include city and street or street intersection):

Name: _____ City/Street: _____

Phone: _____

Do we have your permission to obtain your medication list from your pharmacy? ❑ Yes ❑ No