STONE RIDGE
— DERMATOLOGY —
MEDICAL | SURGICAL | AESTHETIC

Initial Patient Registration Form

Patient's Name: ___________________________________ Date of Birth: ____________________

Who is your Primary Physician/Provider? ____

Referring Physician/Provider if different? ____

Have you been seen by Dr. Chaudhry at *any* office location within the past 3 years? ________ YES ________ NO

Who is your Emergency Contact:

Name: ____Relationship: ____________ Phone: ________________

Concerning matters of my health, lab results, and appointments, I, the patient/patient representative authorize Dr. Chaudhry and/or members of her staff to speak with and share my information with the above Emergency Contact: ______ Yes _______ No

If you'd like us to share information with an additional or other contact, please provide the information below:

Name: ____ Relationship: _____________ Phone: ________________

Name: ____ Relationship: _____________ Phone: ________________

I ___ALLOW ___ DO NOT ALLOW test results and other specific information regarding my care to be left on my answering machine or voicemail. The above information is accurate to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Stone Ridge Dermatology PLLC or insurance company to release any information required to process my claims.

Signature of Patient/Patient Representative: ______________________________ Date: _________________

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