KNIGHT DERMATOLOGY INSTITUTE
The Center for Skin Cancer & Cosmetic Laser Skin Surgery

PATIENT REGISTRATION FORM

J. Matthew Knight, M.D.
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Orlando, FL 32801
(407) 992-0660 Phone
(407) 992-7702 Fax

Name_____
Last **First** **MI**

Date of Birth _____/_____/_____ Age_____ Sex_____ Marital Status_____

SSN _____ Email _____

Mailing Address_____
City State Zip Code

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

Employer_____ Occupation_____

PARENT OR RESPONSIBLE PARTY (If Different From Patient)

Name_____
Last First MI

Date of Birth _____/_____/_____ Sex_____ SSN_____

Mailing Address_____
City State Zip Code

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____

INSURANCE INFORMATION (Please Present Insurance Card at Time of Check-In)

Primary Insurance Name_____
Insurance Address_____
Name of Policy Holder_____
DOB____/____/____ SSN of Policy Holder_____
Insurance Phone No._____
Insured's ID No._____
Group No._____
Relationship of Patient to Policy Holder_____

Secondary Insurance Name_____
Insurance Address_____
Name of Policy Holder_____
DOB____/____/____ SSN of Policy Holder_____
Insurance Phone No._____
Insured's ID No._____
Group No._____
Relationship of Patient to Policy Holder_____

EMERGENCY CONTACT
Person to contact in case of emergency _____

Address_____ Phone (_____) _____

Referring Doctor_____

How may we contact you regarding appointments, follow up, biopsy results, lab results, etc.?
May we call you at home? □Yes □No
May we call your cell? □Yes □No
May we call your place of employment? □Yes □No
May we leave a message on your voicemail at home? □Yes □No
May we leave a message on your voicemail at your cell? □Yes □No
May we leave a message at your place of employment? □Yes □No
May we discuss your medical condition or PHI with a member of your household? □Yes □No

May we email results to you? □Yes □No Email Address: _____
May we email or text message you regarding promos or specials? □Yes □No

I hereby request the professional services of J. Matthew Knight, M.D., and agree to financial responsibility as indicated in the paragraph below:
I understand that Knight Dermatology Institute will only file insurance claims to plans in which they participate. If I am covered by a plan that they do not participate in, payment will be expected of me at the time of service. I authorize the release of medical information necessary to process claims, and also authorize payment of medical benefits to the physician. If my insurance does not pay, I will be financially responsible for payment in full.

Signature of Patient or Legal Guardian_____ Date_____/_____/_____