



PATIENT REGISTRATION FORM

J. Matthew Knight, M.D.
801 N. Orange Avenue, Suite 520
Orlando, FL 32801
(407) 992-0660 Phone
(407) 992-7702 Fax

Name _____
Date of Birth _____ / _____ / _____ Age _____ Sex _____ Marital Status _____
SSN _____ Email _____
Mailing Address _____
Home Phone (_____) _____ Work Phone (_____) _____ City _____ State _____ Zip Code _____
Employer _____ Occupation _____

PARENT OR RESPONSIBLE PARTY (If Different From Patient)

Name _____
Date of Birth _____ / _____ / _____ Sex _____ SSN _____
Mailing Address _____
Home Phone (_____) _____ Work Phone (_____) _____ City _____ State _____ Zip Code _____

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

Primary Insurance Name _____ Secondary Insurance Name _____
Insurance Address _____ Insurance Address _____
Name of Policy Holder _____ Name of Policy Holder _____
DOB ____/____/____ SSN of Policy Holder _____ DOB ____/____/____ SSN of Policy Holder _____
Insurance Phone No. _____ Insurance Phone No. _____
Insured's ID No. _____ Insured's ID No. _____
Group No. _____ Group No. _____
Relationship of Patient to Policy Holder _____ Relationship of Patient to Policy Holder _____

PHARMACY INFORMATION

Name _____ Phone (____) _____
Address _____
Person to contact in case of emergency other than spouse _____
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 leave a message on your voicemail at home? Yes No
May we call your cell? Yes No May we leave a message on your voicemail at your cell? Yes No
May we call your place of employment? Yes No May we leave a message at your place of employment? Yes No
May we discuss your medical condition with a member of your household? Yes No

If yes, whom _____ Relationship _____

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 ____/____/____