Toll Free 1 (877) NRV-DERM (678-3376)
www.newriverdermatology.com

2617 Sheffield Drive
Blacksburg, VA 24060
(540) 953 2210

2900 Lamb Circle, Ste 200
Christiansburg, VA 24073
(540) 731 6892

710 West Ridge Road, Ste G
Wytheville, VA 24382
(276) 335 2112

PATIENT REGISTRATION

Patient Name: First ______________________ MI ____ Last ______________________

☐ Male ☐ Female Date of Birth ______________ Social Security Number ______________

Billing Address ______________________ City ____________ State ____ Zip ________

Physical Address ______________________ City ____________ State ____ Zip ________

Home Phone ______________________ Cell Phone ______________________

Pharmacy ____________ Location ____________ Email Address ______________________

Employer ______________________ Work Phone ______________ Ext. ________

Employer Address ______________________ City ____________ State ____ Zip ________

Emergency Contact ______________ Relationship ______________ Primary Phone ______________

RESPONSIBLE PARTY INFORMATION

☐ Self ☐ Spouse ☐ Parent ***If Self, please go to insurance section below*** ☐ Male ☐ Female

Spouse/Parent Name ______________________________ Date of Birth ______________

Billing Address ______________________ City ____________ State ____ Zip ________

Home Phone ______________________ Social Security Number ______________________

Cell Phone ______________________ Email Address ______________________

Employer ______________________ Work Phone ______________ Ext. ________

Employer Address ____

INSURANCE INFORMATION

Primary Insurance ______________________ ID # ______________ Group # ________

Secondary Insurance ______________________ ID # ______________ Group # ________

Subscriber Name ______________________________ Date of Birth ______________

AUTHORIZATION FOR RELEASE OF INFORMATION
ASSIGNMENT OF INSURANCE BENEFITS AND PROMISE OF PAYMENT

Authorization is hereby given to release to my insurance company(s) such information that may be necessary for the completion of my clinic insurance claims. I understand I am financially responsible for charges not covered by insurance and assign any insurance benefits to New River Dermatology.

Signature ______________________ Date ______________________