

# REGISTRATION FORM

(Please Print)

## Patient Information

Primary Care Physician/Family Dr.: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First Middle

Is this your legal name?  Yes  No Social Security no: \_\_\_\_\_

If not, what is your legal name? \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female  
(MM/DD/YYYY)

Marital Status:  Single  Mar  Div  Wid  Mr.  Mrs.  Ms.  Miss

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Preferred Phone Number: \_\_\_\_\_  
 Cell  Home Name/Relationship \_\_\_\_\_

Secondary Phone Number: \_\_\_\_\_  
 Cell  Home Name/Relationship \_\_\_\_\_

Email Address: \_\_\_\_\_

## Individuals Authorized to Receive Medical Information

If you'd like us to share your medical information with someone other than your referring doctor please let us know. Records will only be released with your authorization.

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Phone Number: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone number: \_\_\_\_\_

## Authorization & Financial Agreement

I authorize the release of my medical information as needed for insurance claims and to the individual(s) listed above for purposes of my care.

I understand that I am responsible for any charges not covered by my insurance. If additional steps are needed to resolve payment, a 30% collection fee may be added to my unpaid balance.

Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
(MM/DD/YYYY)

Printed Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship \_\_\_\_\_

# DERMATOLOGY OF NOBLESVILLE

116 Lakeview Drive  
Noblesville, IN 46060  
(317) 773-7400 FAX (317) 773-9029

Enclosed are your New Patient Registration forms. Please note that it is the patient's responsibility to verify that Dr. Karl Siebe (Dermatology of Noblesville ) is in network with their insurance. We recommend calling the phone number listed on the back of your insurance card(s) to verify this information.

Please complete the enclosed paperwork.

For your appointment, please bring:

- Your completed registration forms
- Your **physical** insurance cards (digital versions can not be accepted)
- A current list of all medications you are taking, along with the daily dosages

If you have any questions, please do not hesitate to call the office. We look forward to meeting you and are committed to providing you with exceptional dermatological care.

Thank you,

Dr. Karl W. Siebe/lw

M \_\_\_\_\_  
HAS AN APPOINTMENT ON  
 MON.  TUE.  WED.  THUR.  FRI.  SAT.  
DATE \_\_\_\_\_ AT \_\_\_\_\_  
A.M.  
P.M.

**DERMATOLOGY OF NOBLESVILLE**  
**KARL W. SIEBE, M.D.**

116 Lakeview Drive • Noblesville, IN 46060 • (317) 773-7400

IF UNABLE TO KEEP APPOINTMENT, KINDLY GIVE 24 HOURS NOTICE.