MAIN LINE DERMATOLOGY

Patient Registration Form

NAME:____ DATE OF BIRTH: __________________________________

STREET ADDRESS: ____ APT. #___________

CITY: ____ STATE: ___________________ ZIP CODE:______________

PRIMARY PHONE: ________________________☐HOME ☐ CELL SECONDARY PHONE: ________________________☐HOME ☐ CELL

SOCIAL SECURITY NUMBER: ________________MARITAL STATUS: ______OCCUPATION/ EMPLOYER: __________________________

EMAIL ADDRESS: ____ ARE YOU INTEREST IN BOTOX/ FILLERS? ☐ YES ☐ NO

EMERGENCY CONTACT NAME/NUMBER: ____

Gender: ☐ Male ☐ Female **ETHNICITY**: ☐ Hispanic ☐ Non-Hispanic **RACE**: ☐ American Indian ☐ Asian ☐ Black ☐ Caucasian ☐ Other

PRIMARY CARE PHYSICIAN: ____ PHYSICIAN PHONE: _____________________________

PRACTICE NAME AND ADDRESS: ____

____

REFERRING PHYSICIAN: ____PHYSICIAN PHONE: _____________________________

PHARMACY NAME: ____ PHARMACY PHONE: ___________________________

INSURED'S BILLING INFORMATION:

POLICY HOLDER'S NAME: _____________________________________ **HOLDER'S DATE OF BIRTH**: __________________________

RELATIONSHIP TO PATIENT: _____________________________________ PHONE NUMBER: __________________________________

(All minors under the age of 18 must be accompanied by parent or guardian at all visits including suture removal)

PAYMENT REQUESTED AT TIME OF SERVICE

HMO PATIENTS REQUIRE PROPER REFERRAL PRIOR TO TREATMENT - A referral from your Primary Care Physician is required for any and all specialist services. By singing this form, you acknowledge that if you do not have a referral at the time of your visit, you will be held responsible for the full price of services incurred.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Main Line Dermatology and its physicians to release any medical or incidental information that may be necessary for either medical care or in processing application for financial benefits. ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of surgical/ medical benefits to Main Line Dermatology, Inc. and its physicians for services rendered by them or under their supervision. I understand that I am financially responsible for any balance not covered by my insurance. I request that payment of authorized Medicare and or insurer benefits be made on my behalf to Main Line Dermatology, Inc. for services furnished to me by said physicians. I understand that if under Medicare program guidelines, a necessary service is determined to be non-covered; I will personally be responsible for payment. I understand I am financially responsible for any amount denied or partially paid by the Third Party Payer. **PLEASE NOTE: ALL BIOPSIES ARE SENT TO AN OUTSIDE LAB TO BE PREPARED AND/OR INTERPRETED.** I acknowledge receipt of the "NOTICE OF PRIVACY PRACTICES" from this practice.

SIGNATURE: ____ DATE: _______________