☐ Name Change
☐ Insurance Information Change
☐ Address change

Patient Registration Form

PATIENT INFORMATION

(Please Print) Today's Date____/____/____

Name ____
Last *First* *M.I.*

Address ____
Apt # *City* *State* *Zip*

Preferred Phone # ______________ Alternate Phone # ______________ SS#______________
Area Code *Area Code*

Date of Birth____/____/____Age _____Sex: ☐ Male ☐ Female Email Address: ______________

Employer ______________Work Phone ______________ Marital Status ________
Area Code *ext.*

RESPONSIBLE PARTY *(if different from patient)*

Name ____
Last *First* *M.I.*

Address ____
Apt # *City* *State* *Zip*

Preferred Phone # ______________ Alternate Phone # ______________ SS#______________
Area Code *Area Code*

Date of Birth____/____/____Age _____Sex: ☐ Male ☐ Female ☐ Employment Status ☐ Full Time ☐ Part Time ☐ Student ☐ Retired

Employer ______________Work Phone ______________ Marital Status ________
Area Code *ext.*

INSURANCE INFORMATION *(Please present insurance card at time of check in.)*

Primary Insurance Name______________
Ins. Address ______________
Name of Primary Insured ______________
Insured's ID#______________
Group # ______________
Relationship of patient to the Insured______________
SS# of Primary Insured ______________
Employer Name (If Group Policy) ______________
Date of Birth____/____/____

Secondary Insurance Name______________
Ins. Address ______________
Name of Insured ______________
Insured's ID# ______________
Group # ______________
Relationship of patient to the Insured ______________
Employer Name (If Group Policy) ______________
Date of Birth____/____/____

In case of Emergency, who should be notified? List two different contacts.

Name ______________ Relationship to Patient ______________Phone (____) ______________

Name ______________ Relationship to Patient ______________Phone (____) ______________

Referred Physician: ______________ Primary Care Physician: ______________

Nature of Problem:______________ Allergies: ______________

I hereby authorize treatment by The Dermatology Group. I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. I understand that any amount that my insurance company does not pay for any reason is due from me. We accept payment in the form of cash, checks or credit cards. I authorize the assignment of all medical benefits to which I am entitled, including Medicare, private insurance, group policy benefits, and other health plans to this practice. Your signature below signifies your understanding and willingness to comply with this policy. If a member of a managed care group, I understand that it is my responsibility for services rendered if they are denied due to non-covered or non-authorized reasons.

____ Date____/____/____
(i.e., spouse, parent, caretaker)

Patient Signature ______________________________ Date____/____/____
(If under 18 years of age, a responsible party must sign)

Responsible Party Signature ______________________ Date____/____/____