NORTH BRANCH DERMATOLOGY

REGISTRATION FORM

Today's date:	Provider:

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Sex: ❑ M ❑ F

Address:	Cell Phone No. ( )	Home phone no.: ( )

Unit/Apt	City:	State:	ZIP Code:

Primary Care Physician:	Referred by:	

Race ❑ Asian ❑ Other ❑ White ❑ Black ❑ Hispanic

Email Address:

Other family members seen here:

RESPONSIBLE PARTY (IF NOT PATIENT – PARENT, SPOUSE)

Person responsible for bill: Name:	Birth date: / /	Cell Phone no. ( )	Home phone no.: ( )

Address (if different):

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Permission to discuss your care — Signature below authorizes us to speak with this person/leave messages

Who we may discuss your medical condition with:

Name:	Relationship	Home Phone: ( )	Cell Phone: ( )

Messages

May we leave personal medical information on:	Answering Machine: Yes No	Cell Phone Yes No	Home Phone: Yes No

Patient/Guardian signature — Date

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Cell phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize North Branch Dermatology or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Pharmacy Information:

Name:

Address:

Phone Number:

Payment Policies:

Payment is expected at the time of visit. If you are covered by insurance, we will submit charges to the insurance on your behalf. **Copays and charges for any non-covered or cosmetic services are to be paid at the time the services is rendered.**

All returned checks will be subject to a charge of **$25.00.**

In divorce situations, **the parent that brings the child to the appointment is responsible for payment of the charges.** This includes copayments, regardless of divorce decree. If payment issues exist, they must be resolved between the parents.

By signing below I am indicating that I have read and understand the payment policies

Receipt of Patient Privacy Notice:

By signing the form below I am indicating that a copy of the patient privacy notice was made available to me to review.

Signature: _____

Date: _____