❑ 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*

Home Phone _____ Cell _____ 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.*

RESPONSIBLE PARTY *(if different from patient)*

Name _____
Last *First* *M.I.*

Address _____
Apt # *City* *State* *Zip*

Home Phone _____ Cell _____ 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 by: _____ 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 responsibilty 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 ___/___/___

10/06