

Dermatology Associates, P.C. Patient Registration Form

PATIENT INFORMATION (please print)

First Name _____ Middle Initial _____ Last Name _____
Home Address _____
City _____ State _____ Zip Code _____
Billing Address (if different) _____
Work Address (if different) _____
Home Phone _____ E-mail Address _____
Work Phone _____ Fax _____ Cell Phone _____
Date of Birth _____ Social Sec. # _____ Sex M F
Marital Status S M D W Other _____ How did you hear about us? _____
Referring Provider _____ Primary Care Provider _____
Employer _____ Employer Phone _____
Responsible Party Last Name (if applicable) _____ First _____ MI _____
Emergency Contact _____ Relationship _____ Phone _____

INSURANCE INFORMATION

Primary Insurance _____
Policy Holder Name _____ DOB _____ SS# _____
Address _____ City, State, Zip _____
Policy I.D. _____ Group # _____ Member # _____
Co-Pay Amount _____ Policy Effective Dates: From: _____ To: _____
Patient Relation to Policy Holder: Self Spouse Child Other: _____
Secondary Insurance _____
Policy Holder Name _____ DOB _____ SS# _____
Address _____ City, State, Zip _____
Policy I.D. _____ Group # _____ Member # _____
Co-Pay Amount _____ Policy Effective Dates: From: _____ To: _____
Patient Relation to Policy Holder: Self Spouse Child Other: _____

BILLING INFORMATION

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn this service over to collection for non-payment after 90 days, then the patient is responsible for the bill, the interest, and collection and attorney fees.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER:

I hereby authorize payment directly to the undersigned Provider for my charges.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the undersigned Provider to release any information acquired in the course of my examination or treatment to my insurance company in writing or by fax.

Signature (Patient or Parent of Minor) _____ Date: _____