

PATIENT REGISTRATION

TODAY'S DATE: _____ SOC. SEC #: _____ Patient #: _____

NAME: _____ SEX: F or M
Last First M.I.

BIRTHDATE: _____ AGE: _____ MARITAL STATUS: S M D OTHER

ADDRESS: _____
CITY STATE ZIP

PRIMARY PHONE: () _____ SECONDARY PHONE: () _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: () _____

PT'S EMPLOYER: _____ PHONE: () _____

PHYSICIAN/OFFICE THAT REFERRED: _____

HOW DID YOU HEAR ABOUT US: _____

IMPORTANT – PLEASE READ: If the patient is under 18 years of age or covered under a parent's or guardian's insurance plan, please complete following information. Law requires that we obtain permission from the parent or legal guardian PRIOR to any medical treatment. A parent or legal guardian must be present for any patient that is under 18 years of age.

***NAME OF RESPONSIBLE PARTY:** _____ ***Patient relationship to responsible party:** _____

_____ (_____)
Last First M.I. SOC.SECURITY #

ADDRESS: _____
City State Zip

PHONE: () _____ WORK PHONE: () _____

INSURANCE INFORMATION:

PRIMARY INS. NAME: _____ SECONDARY INS. NAME: _____

NAME OF POLICY HOLDER: _____ NAME OF POLICY HOLDER: _____

POLICY HOLDERS BIRTHDATE: _____ **POLICY HOLDERS BIRTHDATE:** _____

POLICY ID#: _____ POLICY ID#: _____

GROUP #: _____ GROUP #: _____

I authorize the release of medical information to any physician/healthcare provider involved in my care; my primary care or referring physician, to consultants and also as necessary to process insurance claims and applications. I also authorize payment of medical benefits to the physician. IF FOR ANY REASON MY INSURANCE POLICY DOES NOT COVER INCURRED COSTS, I AM AWARE THAT I WILL BE RESPONSIBLE FOR ALL COSTS.

Patient or Responsible Party Signature

Date

MEDICARE PATIENTS ONLY ~ MEDICARE AUTHORIZATION:

I authorize Dermatology Specialists, P.A. to release information about me to the Health Care Financing Administration or its intermediaries any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party that accepts assignment. IF FOR ANY REASON MY INSURANCE POLICY DOES NOT COVER INCURRED COSTS, I AM AWARE THAT I WILL BE RESPONSIBLE FOR ALL COSTS.

Patient or Responsible Party Signature

Date