PATIENT REGISTRATION

Dermatology Specialists, P.A.

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: ( ) ________________________________

PHARMACY NAME: __________________________________ **PHARMACY 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. ***Due to the HIPAA privacy rules, if you are over the age of 18 and would like medical care discussed with others (parent/guardian/family members), please ask to sign a HIPAA Disclosure Form.***

*** RESPONSIBLE PARTY:** ***Patient relationship to responsible party**: ___________________________________

NAME:____ (________________________)

Last First M.I. **SOC. SEC. #**

ADDRESS: ____

CITY STATE ZIP

PHONE: ( ) ________________________________ WORK PHONE: ( ) _______________________________

INSURANCE INFORMATION:

PRIMARY INS. NAME: _______________________________

NAME OF POLICY HOLDER: _______________________________

POLICY HOLDERS BIRTHDATE: ___________________________

POLICY ID#: _______________________________

GROUP #: _______________________________

POLICY HOLDERS EMPLOYER: ____________________________

SECONDARY INS. NAME: _______________________________

NAME OF POLICY HOLDER: _______________________________

POLICY HOLDERS BIRTHDATE: ___________________________

POLICY ID#: _______________________________

GROUP #: _______________________________

POLICY HOLDERS EMPLOYER: ____________________________

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 AND/OR REPLACEMENT PLAN 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**