ADVANCED DERMATOLOGY

Registration Patient Information

Date: _____

Last Name: _____ First Name: _____ Middle Name: _____

DOB: _____ / _____ / _____ SSN: _____ (please provide for insurance purposes) Sex: _____

The following are required: Race: _____ Preferred Language: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Home Address: (Primary) _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Employer: _____

Email Address: _____

Person to notify in case of an emergency: _____ Phone: _____

How would you like to be contacted for appointment reminders: ____Phone ____Email ____Text

Primary Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

NAME & DOB OF INSURED: (If Different from the Patient) Name: _____ DOB: ____/____/____

Insurance companies require this information for claim processing. SSN: _____

PARENT and/or GUARDIAN: (If Patient is under the age of 18):

Last Name: _____ First Name: _____ Middle Name: _____

Home Address: (Primary)

_____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: ___/____/____ SSN: _____ Sex: (Circle) FEMALE MALE Employer: _____

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. I understand that I am responsible for any charges deemed not medically necessary by my insurance company or otherwise not covered by my insurance company, including, but not limited to co-pays, deductibles and co-insurance payments.

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 with which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of CASH, CHECK, VISA, MASTERCARD, DISCOVER, DEBIT CARDS, MONEY ORDERS, and CASHIERS CHECKS. We also participate with Care Credit Financing. All balances due that do not get paid within the first 30 days are subject to finances which will accrue interest monthly.

PATIENT or Responsible Party Signature: _____ Date _____/_____/_____

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