DERMATOLOGICAL CARE

PATIENT REGISTRATION FORM

PATIENT

This section refers to the PATIENT ONLY (make corrections as necessary)

Name: **Sex:** **Date of Birth:**

Address:

City, State, Zip: **SSN#:**

Home Phone: **Cell Phone:**

Employer: **Phone:**

Primary Care Physician: **Phone:**

Referred by: **Phone:**

RESPONSIBLE PARTY

Review/complete if person responsible for the bills is NOT the PATIENT!

Name: **Sex:** **Date of Birth:**

Address:

City, State, Zip: **SSN#:**

Home Phone: **Work Phone:** **Employer:**

INSURANCE

Please list required information pertaining to your insurance coverage. If you have multiple coverage, supply information for both carriers

Pri Carrier:	**Sec Carrier:**
Insured:	**Insured:**
Date of Birth: **SSN#:**	**Date of Birth:** **SSN#:**
Patient Relationship:	**Patient Relationship:**
Insured ID:	**Insured ID:**
Group #:	**Group #:**
Insurance Address:	**Insurance Address:**
Copay:	**Copay:**

PHONE CALLS

Do we have permission to:

Leave messages concerning your appointment, test results, and responses to patient phone calls?

Home phone: ___Yes ___ No

Cell Phone: ___ Yes ___No

Work phone: ___ Yes ___ No

Discuss your medical condition with a member of your household ____Y____N

If yes, whom? (1)_____________________________________ Relationship: ________________________

(2)_____________________________________ Relationship: ________________________

AUTHORIZATION

I hereby give **Dermatological Care** my consent to any necessary medical evaluation and treatment. I hereby authorize release of information and/or photos between any of my treating physicians; to my insurance company to process my claim and authorize payment directly to **Dermatological Care**, benefits otherwise payable to me. I understand I am financially responsible for charges not paid in a timely manner by my insurance. The above information is correct to the best of my knowledge.

Signed: ____ **Date:** ____________________