Patient Registration

Please complete front and back and bring with you to your appointment

PLEASE PRINT	Emergency Contact Information
Last Name:	Name:
First Name: Middle Initial:	Relationship to Patient:
Date of Birth: Sex: M or F	Phone:
Social Security No.:	
Address:	**Guarantor Information (to whom statements are sent)**
Zip:	Name:
City:	Address:
State:	City: State: Zip:
Home Phone: ( )	Phone: ( )
Employer: Work Phone: ( )	Guarantor DOB: Guarantor SSN:
Mobile Phone: ( )	Did a physician refer you to our practice? Yes or No
Marital Status: (check one) Single___ Married____ Divorced___ Widowed____	Name of referring physician:

Primary Insurance Information

Insurance Company:	
Policy Information	**Policy Holder**
Patient's relationship to policy holder: (please check one) Self_____ Spouse_____ Child_____	Last Name:
ID/Certification No.:	First Name:
Policy/Group No.:	Middle Name:
	Address:
	City: State: Zip:
Copay :	Social Sec Number:
	Date of Birth: Sex: M or F
	Employer:

Secondary Insurance Information	
Insurance Company:	
Policy Information	**Policy Holder**
Patient's relationship to policy holder: (please check one) Self_____ Spouse_____ Child_____	Last Name:
ID/Certification No.:	First Name:
Policy/Group No.:	Middle Name:
	Address:
	City: State: Zip:
Copay :	Social Sec Number:
	Date of Birth: Sex: M or F
	Employer:

ASSIGNMENT AND RELEASE:

- **I hereby assign my insurance benefits to be paid directly to the physician.**
- **I understand that I am financially responsible for all non-covered services and any covered services not paid by insurance within 90 days.**
- **I authorize the physician to release any information required to process this claim.**
- **I give permission to D.A. to leave messages on my answering machine and/or discuss health information with immediate family members.**
- **I have received notice of privacy practices.**

Signed_____ **Date:**

CONFIDENTIAL COMMUNICATIONS

I authorize Dermatology Associates to share my health information with the individuals listed below. This authorization will remain in effect for one year unless I notify Dermatology Associates otherwise.

_____

Name **DOB** **Relationship**

_____

Name **DOB** **Relationship**

_____

Name **DOB** **Relationship**

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Name **DOB** **Relationship**