PATIENT REGISTRATION FORM

PATIENT INFORMATION

(Please Print)

Today's Date ____/____/____

Name _____
Last *First* *Middle Initial*

Mailing Address _____
Street

_____
City *State* *Zip*

Home Phone _____ Work Phone _____
Area Code *Area Code*

Cell Phone _____
Area Code

Date of Birth ____/____/____ Age_____ Sex_____ Marital Status: ___Single ___Married ___Divorced ___Widowed

Occupation_____ RacelEthnicity: _____

INSURANCE HOLDER/Responsible Party *(If different from patient)*

Name _____
Last *First* *Middle Initial*

Mailing Address _____
(Only if different) *Street*

_____
City *State* *Zip*

Home Phone_____ Work Phone_____
(Only if different) *Area Code* *Area Code*

Date of Birth _____/_____/_____ Sex_____ Occupation _____

Pharmacy Name _____

INSURANCE INFORMATION *(Please present insurance card at time of check-in)*

Primary Insurance Name _____

Name of Insured _____

Insured's ID #_____ Birth date _____

Relationship of patient to the insured _____

Employer Name_____

Secondary Insurance Name_____

Name of Insured _____

Insured's ID#_____Birth date _____

Relationship of patient to the insured _____

Employer Name_____

Referred by: _____

Primary Care Physician: _____

- I have received a copy of Dermatology Associates at Crystal Run, Notice of Privacy Practices
- I authorized 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 authorized payment of medical benefits to the physician.

Patient Signature: _____ Date ____/____/_____

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 policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature: _____ Date ____/____/_____

6/4/2014