

DERMATOLOGY ASSOCIATES AT CRYSTAL RUN
PATIENT REGISTRATION FORM
(Please Print)

PATIENT INFORMATION

Today's Date: _____

Name: _____
Last First Middle Initial

Mailing Address: _____
Street

City State Zip

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Date of Birth: _____ Age: _____ Sex: _____ Marital Status: Single Married Divorced Widowed

Occupation: _____ Race / Ethnicity: _____

INSURANCE HOLDER / Responsible Party (if different from patient)

Name: _____
Last First Middle Initial

Mailing Address: _____
Street

City State Zip

Home Phone: _____ Work Phone: _____

Date of Birth: _____ Age: _____ Sex: _____ Occupation: _____

Local Pharmacy _____

Mail-Away Pharmacy _____

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 authorize the release of medical information to my primary care physician 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.

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 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature: _____ Date _____