

ADVANCED DERMATOLOGY & SKIN SURGERY, P.A.

PATIENT REGISTRATION

(Please Print)

Today's Date ___/___/___

Name _____
Last First M.I.

Mailing Address _____

City State Zip Code

Home Phone _____ Cell Phone _____ Work Phone _____
(Area Code) (Area Code) (Area Code)

Date of Birth ___/___/___ Age ___ Sex ___ Marital Status ___ Email _____

Race (circle) Caucasian African American Asian American Indian Native Alaskan Hawaiian Pacific Islander

Ethnicity (circle) Non-Hispanic/Latino OR Hispanic/Latino

Language (circle) English Spanish French German Vietnamese Italian Mandarin

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name _____
Last First M.I.

Address _____

City State Zip Code

Home Phone _____ Cell Phone _____ Work Phone _____
(Area Code) (Area Code) (Area Code)

Date of Birth ___/___/___ Sex _____

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

Primary Insurance Name _____ Secondary Insurance Name _____

Ins. Address _____ Ins. Address _____

Name of Insured _____ Name of Insured _____

Insured's ID# _____ Insured's ID# _____

Insured's SSN _____ Insured's SSN _____

Group # _____ Group _____

Insured's Date of Birth _____ Insured's Date of Birth _____

Employer Name _____ Employer Name _____

Employer Address _____ Employer Address _____

Employer Phone (____) _____ Employer Phone (____) _____

Relationship of patient to the Insured _____ Relationship of patient to the Insured _____

Pharmacy of choice _____ Phone _____

Referred by _____

Primary Care Physician _____

Please see other side.

Advanced Dermatology & Skin Surgery

I have read and understand the financial and office policy of the practice and I agree to be bound by its terms. I hereby authorize Advanced Dermatology & Skin Surgery to collect financial information arising from my treatment. This includes, but is not limited to, hospital and laboratory services. I also understand and agree that such terms may be amended from time-to-time by the practice.

Patient/responsible party signature _____ Date ____/____/____

Please **print** the name of the patient _____

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.

Patient/responsible party 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 payment 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 at the time of service in some instances, prior to your visit. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. Deposits may be required prior to scheduling certain procedures. Delinquent accounts will be charged an administration fee of \$50. Your signature below signifies your understanding and willingness to comply with this policy.

Patient/responsible party signature _____ Date ____/____/____