# PATIENT REGISTRATION

Dear Patient/Parent or Guardian,
It is the practice of this office to provide the highest quality of care possible. Part of accomplishing this mission includes proper direction of test results, correspondence, health insurance claims, and account information. Therefore, it is necessary for us to request the following from you. Please complete *every item* on both sides of this registration form so that we may better serve you with as few delays as possible. Thank you.

## PATIENT INFORMATION

Last Name:______________________ First Name:______________________ M.I.___
Street Address/Apt#: ______________________________________________
City: ____________________________ State: ________ Zip Code: __________
Home Phone #: ______________________
Work Phone #: ______________________
Cell Phone #: ______________________
Date of Birth: ______________________
Social Security #: __________________________
Sex: ( ) Male ( ) Female Marital Status: [] Single [] Married
Is this patient a student? [] No [] Yes If "yes", indicate [] Part Time [] Full Time
Employer: __________________________ Occupation: ________________
Employer's Address: ______________________________________________
Driver License #:______________ REFERRING PHYSICIAN: ________________
Emergency Contact: ____________________ Emergency Tel. #: ________________

## INSURANCE INFORMATION
**(This section must be completed if billing an Insurance Company)**

Primary Insurance Co.:____________________ Insured's Name:________________
ID #: ______________________________ Group #: ____________________
Insured's Address: ______________________________________________
Insured's Prim. Tel. #: ________________ Insured's Sec. Tel. #: ________________
Insured's Date of Birth: ____________________ Insured's Sex: [] Male [] Female
Insured's Employer: ________________ Relationship of Patient to Insured:__________

Secondary Insurance Co.:____________________ Insured's Name:________________
ID #: ______________________________ Group #: ____________________
Insured's Address: ______________________________________________
Insured's Prim. Tel. #: ________________ Insured's Sec. Tel. #: ________________
Insured's Date of Birth: ____________________ Insured's Sex: [] Male [] Female
Insured's Employer: ________________ Relationship of Patient to Insured:__________

**CONTINUE ON REVERSE SIDE**

Responsible Party: (to be completed ONLY if party is not the patient or not listed as the insured)

Last Name: ______________________ First Name: ______________________ M.I.____
Street Address/Apt#: ____________________________________________
City: ______________________ State: ____________ Zip Code: __________
Primary #: ______________________ Secondary #: ______________________
Sex: ( ) Male ( ) Female Date of Birth: ______________________
Social Security #: ____________________________________________
Relationship to Patient: ____________________________________________

**Reason for visit:** ____________________________________________

**What medications does the patient currently take?** ______________________
____________________________________________
____________________________________________

**Does the patient have any drug allergies?** __________ (if "YES", please list)
____________________________________________

**PAYMENT POLICY:**

All professional services rendered are charged to the patient. The patient is responsible for payment regardless of insurance coverage. **Full payment** is expected at time of each office visit unless satisfactory arrangements have been made in advance. Billing information will be provided to expedite patient's reimbursement from private carrier.

In all instances when a health insurance company with whom this office is a participating provider covers the patient, we will be verifying insurance, eligibility directly with your insurance company. When necessary, we are happy to discuss this information with you in an effort to justify the amount you will be expected to pay. However, it is ultimately the responsibility of your insurance company to provide education on the benefits available to you. All co-payments, coinsurances, and deductibles are due and payable at the time services are rendered.

**AUTHORIZATION OF PAYMENT:**

I hereby authorize the provider of services to release medical information concerning my examination and/or treatment for insurance purposes and to receive direct payment for medical benefits payable to TheSkinMD.com for services rendered.

I, the undersigned, have completed this registration form to the best of my knowledge. Also, I have read and fully understand the payment policy and authorization of payment outlined above.

**Signature:**______________________________ **Date:**__________________
**Printed Name:**____________________________________________