

PATIENT INFORMATION

Last Name: First Name: M.I.
Street Address/Apt#:
City: State: Zip Code:
Home Phone #: Work Phone #:
Cell Phone #: Email:
Date of Birth: Sex: () Male () Female
Social Security #: Marital Status: () Single () Married () Other
Employer: Occupation:
Driver License #: REFERRING PHYSICIAN:
Emergency Contact: Emergency Tel. #:

INSURANCE INFORMATION

Primary Insurance Co.: Insured's Name:
Insured's Date of Birth: Relationship of Patient to Insured:

Secondary Insurance Co.: Insured's Name:
Insured's Date of Birth: Relationship of Patient to Insured:

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:
Home #: Cell #:
Date of Birth: Relationship to Patient:

*IF YOU ARE A NEW PATIENT, HOW DID YOU HEAR ABOUT US?

Reason for visit:

What medications does the patient currently take?

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

PAYMENT POLICY/AUTHORIZATION OF PAYMENT:

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. All co-payments, coinsurances, and deductibles are due and payable at the time services are rendered.

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. The charges collected are estimated charges and the patient will be reimbursed if the office has over collected.

A 24hr notice is required for all cancellations/reschedules or a \$50 No Show fee may be assessed.

Signature: Date:

Printed Name: