DERMATOLOGY AFFILIATES MEDICAL GROUP

PATIENT REGISTRATION SHEET

New PT _____ Returning PT_____

Patient Name: _____ Date of birth _____ Age_____
Last First Middle Initial

Email address _____@_____ Sex _____ Marital Status_____

Address _____ City _____ State_____ Zip_____

Phone _____ Cell Phone _____

Occupation _____ Employer _____

Employer's Address_____ Employer's Phone _____

MAY WE CALL YOU AT WORK? ___YES ___NO MAY WE LEAVE A MESSAGE ON YOUR VOICEMAIL ___YES ___NO
MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR VOICE MAIL AT HOME ____YES ____ NO

IF PATIENT IS UNDER 18, RESPONSIBLE PARENT/GUARDIAN

Parent/Guardian name: _____ Relationship_____

Address: _____

Phone_____ Work _____ Cell _____

EMERGENCY CONTACT

Person to notify in case of emergency: _____ Relationship_____

Home phone _____ Cell or Work phone _____

PRIMARY INSURANCE INFORMATION (PLEASE PROVIDE COPY OF INSURANCE CARDS)

Insurance Company _____

Name of Insured _____ DOB _____ SS _____

SECONDARY INSURANCE INFORMATION (PLEASE PROVIDE COPY OF INSURANCE CARDS)

Insurance Company _____

Name of Insured _____ DOB _____ SS _____

CONSENT FOR TREATMENT
I CONSENT TO TREATMENT AS NECESSARY OR DESIREABLE TO THE CARE OF THE PATIENT FIRST NAMED ABOVE, INCLUDING BUT NOT RESTRICTED TO WHATEVER DRUG, MEDICINE, PERFORMANCE OF OPERATIONS AND CONDUCT OF LABORATORY, X-RAY OR OTHER STUDIES THAT MAY BE USED BY THE ATTENDING DOCTOR OR HIS/HER NURSE OR QUALIFIED DESIGNATE
PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE _____ **DATE**_____

I herby authorize the release of any medical information to insurance carriers to process a claim and request payment either to myself or to **DERMATOLOGY AFFILIATES** for medical service rendered. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY MY INSURANCE**. Payment is expected from you at time of service for "your part" of the charges.
In the event that you are unable to make a scheduled appointment, please call the office 12 hours in advance or leave a message with our answering service 12 hours before. If you are a "No Show" for your appointment, YOU WILL BE CHARGED FOR YOUR MISSED APPOINTMENT A FEE OF $50.00. If you and your family have three "no shows" you may be dismissed from the practice.

PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE _____ DATE_____

UPDATE_____ INITIALS_____
UPDATE_____ INITIALS_____