



DERMATOLOGY
PROFESSIONALS, PA

Minor Registration Form

Account# _____

(This information is necessary for our files and will be considered confidential.)

Provider: AEA TJG PBL NTM BRW KJN

Minor Policy: It is required that a parent/legal guardian must accompany a minor child to a new patient visit. If needed, a form is available from the reception staff authorizing another adult to accompany the minor child to follow up appointments. The form must be completed by a parent/legal guardian prior to the appointment or the appointment may need to be rescheduled.

Parent/Guardian Initials _____

Please circle the location you would prefer for any future appointments: (select only one)

Baxter Bemidji Outreach Locations: Aitkin Bigfork Crosby Little Falls Wadena

Minor's Full Name _____

Social Security # _____ Date of Birth _____

Gender: Male ___ Female ___ Language: English ___ Other: _____

Race: White ___ Native American ___ Black ___ Hispanic ___ Asian ___ Hawaiian/Pacific Islander ___ Other: _____

Accompany Parent/Legal Guardian Information: Parent 1

Full Name _____ Relationship _____

Gender: Male ___ Female ___ Date of Birth _____ Social Security # _____

Mailing Address _____

City _____ State _____ Zip Code _____

Preferred Phone # (_____) _____ - _____ Cell Phone _____ Land Line _____

Alternate Phone # (_____) _____ - _____ Cell Phone _____ Land Line _____

Email: _____

Employer: _____ Work Phone # (_____) _____ - _____

Additional Parent/Legal Guardian Information: Parent 2 (Please complete to verify person as parent/guardian so they may receive information regarding this account or in the event of an emergency)

Full Name _____ Relationship _____

Gender: Male ___ Female ___ Date of Birth _____ Social Security # _____

Same address as above ___ Mailing Address _____

City _____ State _____ Zip Code _____

Preferred Phone # (_____) _____ - _____ Cell Phone _____ Land Line _____

Employer: _____ Work Phone # (_____) _____ - _____

Primary Insurance Information

Name of Insurance: _____ Co-Pay \$ _____ (due day of service)

Group # _____ ID # _____

Policy Holder (If other than patient): Full Name _____ Relationship _____

Male _____ Female _____ Date of Birth _____

Same Address _____ Different Address; _____

City _____ State _____ Zip Code _____

Phone # (_____) _____ - _____ Cell Phone _____ Land Line _____

Secondary Insurance Information

Name of Insurance: _____ Co-Pay \$ _____ (due day of service)

Group # _____ ID # _____

Policy Holder (If other than patient): Full Name _____ Relationship _____

Male _____ Female _____ Date of Birth _____

Same Address _____ Different Address; _____

City _____ State _____ Zip Code _____

Phone # (_____) _____ - _____ Cell Phone _____ Land Line _____

I hereby assign payment of authorized medical benefits to include major medical benefits to which I am entitled: To be made on my behalf to Dermatology Professionals, PA For any services furnished me by that Practitioner. I authorize release of medical information needed to determine these benefits payable to related services. I understand that I am financially responsible for all charges whether or not paid by said insurance. **I understand copayments are due on the day of services as required by my insurance carrier.** This Facility does not deny any benefits or service because of race, color, national origin, age gender, and disability, religious or political beliefs. If you feel you have been discriminated against, you may file Complaint of Discrimination with the Administrator of this Facility. You will not suffer any penalty because you file a complaint. **I hereby acknowledge that I have been offered a copy of both the Dermatology Professionals, PA Financial Policy and the Notice of Privacy Practices.**

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events. I consent to the receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voicemail, answering system, or with another individual, if I am unavailable at the number provided by me.

Photographs: I hereby give permission to my provider or any assistant designated, to take photographs to enhance my medical record and for diagnostic/monitoring purposes. I understand that they may show them to other health professionals to assist with my care.

I permit a copy of this authorization to be used in place of the original.

SIGNATURE: _____ **DATE:** _____

Relationship to Minor: _____