Dermatology Professionals, PA

13359 Isle Drive, Suite 3, Baxter MN 56425

Adult Registration Form **Account#_____**

(This information is necessary for our files and will be considered confidential) Provider: AEA TJG PBL NTM BRW KJN

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

Bemidji Baxter Outreach Locations: Aitkin Bigfork Crosby Little Falls Wadena

Patient's Full Name_____

Marital Status:_____S_____M_____W_____D Social Security #_____

Date of Birth_____ Gender: _____Male _____Female

Preferred Language: _____ English Other: _____

Race: ____White ____Native American ____Black ____Hispanic ____Asian ____Hawaiian

Other: _____

***Emergency Contact:** Do you want to list someone as an emergency contact? YES_____ NO_____

Name: _____ Relationship: _____

Phone # for Emergency contact: Same as Patient_____ Different Phone #: _____

Preferred Phone # for **Patient** (____) _____-_____ __Cell Phone __Land Line

Alt Phone # (____) _____-_____ __Cell Phone __Land Line .

Email: _____

Mailing Address _____

City_____State_____ Zip Code_____

Employer:_____

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 herby 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. In addition, I agree to pay any additional charges related to the cost of collections (including but not limited to, collections agency fees reasonable attorney fees and court costs), In the event that I would fail to pay my bill**. 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 at with my care.

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

SIGNATURE:_____DATE:_____