

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 T JG K L J P B L N T M B R W K J N

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

Bemidji Baxter Grand Rapids

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 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. 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:** _____