DERMATOLOGY
PROFESSIONALS, PA

Registration Form

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

Patient's Full Name:____

Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced   Social Security #:______________________

Date of Birth: ______________________   Gender: [ ] Male [ ] Female Other: __________________

Preferred Language: [ ] English [ ] Spanish   Other: ______________________________________

Race: [ ] Caucasian [ ] Native American [ ] African American [ ] Hispanic [ ] Asian Other: ______________

Preferred Phone # for **patient:** (_____) _______ - ____________   Cell phone _______ Landline ________

Alternate Phone #: (_____) _______ - ____________   Cell phone _______ Landline ________

Email: ____

Mailing Address: ____

City: ______________________________ State: _______________ Zip Code: _____________

Employer: ____

***Emergency Contact:** Do you want to list someone as an emergency contact?   [ ] Yes   [ ] No

Name: ______________________________________ Phone #: (_______) _______ - ___________

Relationship: __________________________________

Primary Insurance Information

Name of Insurance: ___________________________________ ID # ____________________

Policyholder (if other than patient) Full Name: ________________________ Relationship: ______________

Gender: [ ] Male [ ] Female Other: __________________   Date of Birth: ______________________

Same Address ________ Different Address: ____

City: _________________________ State: ____________________ Zip Code: _____________

Personal Release

****Personal Rlease:** If you would like to authorize Dermatology Professionals to be able to leave or discuss your appointment (dates/times), financial, and/or medical information with someone other than yourself in your home or person of your choice: (other than doctor).

_________ **NO** _________ **YES**

Personal Release (1)

Name: ____ Relationship: ____

________ Same phone # as Patient Different phone# (______) ______________ - _____________________

Personal Release (2)

Name: ____ Relationship: ____

________ Same phone # as Patient Different phone# (______) ______________ - _____________________

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/Legal Guardian Initials: ________________

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 the 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 a 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 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 receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages to be 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.

Patient Signature or Guarantor: ____

Guarantor (Print): ____ **Date:** ___________________________

Guarantor Date of Birth: __________________________