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 [ ] or Different Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Insurance Information

Name of Insurance: _____ ID # _____

Policyholder (if other than patient) Full Name: _____ Relationship: _____

Gender: [ ] Male [ ] Female Other: _____ Date of Birth: _____

Same Address [ ] or Different Address: _____

City: _____ State: _____ Zip Code: _____

Personal Release

****Personal Release:** 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 #: (_____) _____- _____

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.

No-Show Policy: If you need to cancel or reschedule your appointment with Dermatology Professionals, please notify our office at least 24 hours in advance. Appointments canceled or rescheduled without 24-hour notice, as well as missed appointments (no-shows), will incur a $50 fee. This fee must be paid prior to your next appointment and is not billable to insurance.
Missed appointments are especially costly for a small clinic and limit our ability to provide care to other patients who may require appointments or surgical services. Patients who cancel or miss three appointments without the required 24-hour notice may be permanently discharged from the clinic.

AI Scribe: I authorize the use of AI assisted scribing technology with audio recording during my visit to help accurately document medical information and improve efficiency.

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

Patient Signature: _____ **Date:** _____