

# ADVANCED DERMATOLOGY AND LASER CENTER

## PATIENT REGISTRATION FORM

Date	Chart #
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Patient's Name	Social Security #	Telephone #
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Patient's Mailing Address	City/State/Zip Code
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Patient's Birthdate	Sex	Marital Status	Emergency Contact name	Telephone #
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Patient's Employer/School Name	Telephone #
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Primary Physician/Referring Physician
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## PERSON RESPONSIBLE FOR BILL - PERSON TO RECEIVE BILLING STATEMENT

Name of Person Responsible for Bill	Telephone #
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Person Responsible for Bill's Mailing Address	City/State/Zip Code
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**PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST SO COPIES MAY BE MADE.**

## INSURANCE INFORMATION - INCLUDE MEDICARE OR MEDICAID

Primary Insurance Company Name	Effective Date of Coverage	Group #	Policy #
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Insurance Address	City/State/Zip Code
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Policy Holder's Name	Social Security #	Birthdate	Sex
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Policy Holder's Address	City/State/Zip Code	Patient's Relationship to Policy Holder 1 = Self                      3 = Child 2 = Spouse                    4 = Grandchild
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Policy Holder's Employer	Telephone #
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By signing below:

- 1) I acknowledge the information on this form to be accurate and complete.
- 2) I consent to and authorize the administration of care and treatment to me at Advance Dermatology and Laser Center, and any additional medical treatment that may be, in the judgement of my doctor, necessary or advisable at the time the treatment is performed.
- 3) I hereby authorize my insurance benefits be paid directly to the physician and I accept the responsibility for non-covered services. I authorize physician to release any information to process this claim. This assignment applies to all charges outstanding as of the date of signature and will remain in effect for all current and future charges until revoked in writing.

Do you have your permission to:

- |                                                                   |         |        |
|-------------------------------------------------------------------|---------|--------|
| Leave a message on your answering machine at home?                | ___ YES | ___ NO |
| Leave a message at your place of employment?                      | ___ YES | ___ NO |
| Discuss your medical condition with any member of your household? | ___ YES | ___ NO |

If yes, whom: \_\_\_\_\_ Relationship: \_\_\_\_\_

\_\_\_\_\_  
Patient or Authorized Person's Signature

\_\_\_\_\_  
Date