

PATIENT REGISTRATION FORM

Please present your insurance cards and your photo ID to the receptionist so copies may be made.

Name: _____ Jr. Sr.
First Middle Last

Married Single Other _____ Social Security #: _____ Sex: Male Female

Address: _____
Street Name City State Zip Code

Employer: _____
Name Address Phone

Home Phone: _____ Date of Birth: _____
Month / Day / Year

Cell Phone: _____ E-mail: _____
 Primary Care Physician: _____ Referred by: _____

If self-referred, how did you hear about us?

- Friend Internet Family Member Newspaper
 Television Radio Yellow Pages Other

Emergency Information (Please list someone other than in your household): Name: _____

Phone _____ Address _____ City _____ State _____ Zip Code _____
 Spouse: _____ Spouse's Date of Birth: _____
Month / Day / Year

If Patient is a Minor: It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

Signature of Parent or Legal Guardian _____ (D.O.B.) _____ Date _____

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when assigned claim is filed.

Signature of Patient or Legal Guardian _____ Date _____

PRIMARY INSURANCE: _____
 POLICY #: _____ GROUP #: _____ POLICYHOLDER: _____

SECONDARY INSURANCE: _____
 POLICY #: _____ GROUP #: _____ POLICYHOLDER: _____

Do we have your permission to:

	Yes	No
Leave a message on your answering machine at home?	<input type="checkbox"/>	<input type="checkbox"/>
Leave a message at your place of employment?	<input type="checkbox"/>	<input type="checkbox"/>
Discuss your medical condition with any member of your household?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, whom: _____ Relationship: _____

- I authorize Georgia Skin Cancer & Aesthetic Dermatology to treat the above-named patient as necessary
- I have read the HIPPA privacy policy of Georgia Skin Cancer & Aesthetic Dermatology
- I authorize the release of any medical information to any physician or physician's office, laboratory, pharmacy, hospital or surgical facility involved in my care.

Patient Signature

Date