Associates In Dermatology

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Patient Registration Chart #____________________

Name: ____ DOB: ____________________
Last Name MI First Name

Address: ______________________________________City: _______________State ______Zip__________

Home# _______________________Other #_______________________SS#___________________________

Marital Status: M W D S Sex: F M Student: FT PT Employment Status: F P R N/A

Spouse's Name ___________________ Patient's employer name: _________________________________

Primary / Referring Physician: ____

Insurance Information (from your insurance card)

Primary Insurance Name: ____

Claims Address: ___________________________________ City _______________ State _____ Zip_________

Insurance ID#____________________________________Group#_____________________________________

Subscriber Name ____________________ SS# ____________________ Subscriber DOB __________________

Subscriber Employer____

Patient Relationship to Subscriber: Spouse ___________ Child _____________ Other__________________

Secondary Insurance Name: ____

Claims Address: ___________________________________ City _______________ State _____ Zip_________

Insurance ID# _______________________________________ Group#_________________________________

Subscriber Name _______________________ SS# _________________ Subscriber DOB __________________

Subscriber Employer____

Patient Relationship to Subscriber: Spouse ___________ Child _____________ Other_________________

Medicare Patients

I authorize Associates in Dermatology to release to the Social Security Administration and Health Care Finance, or its intermediaries, any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to Associate in Dermatology. Release of Information

I authorize the release of medical information to my primary care or referring physician, and as necessary to insurance companies to process insurance claims, insurance applications and prescriptions.

I understand that I am ultimately responsible for any/all services rendered to me at the time of service.

____ Date ____________________

Patient or Legal Guardian Signature (If under 18 parent/legal guardian/relation to patient) AD9