PATIENT REGISTRATION INFORMATION

HMO or other Referal # ______________

Account # __________

Co-Payment __________

Please complete both sides of this form.

PATIENT'S PERSONAL INFORMATION

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Male ☐ Female

Name: ______________ (last name) ______________ (first name) ______ (middle init.) ( ) ______ (home phone)

Street Address: ______________ Apt.# ______ City: ______________ State: ______ Zip: ______

Mailing Address: ______________ Apt.# ______ City: ______________ State: ______ Zip: ______

Cell. Phone: ( ) ______________ wk ph: ( ) ______________ E-mail: ______________

Date of Birth: ______/______/______ Age: ______ Social Security # ______ - ______ - ______

Employer: ______________ Occupation: ______________ Driver's License: ______________ State: ______

Spouse's First Name: ______________ Soc. Sec. # ______ - ______ - ______ Date of Birth: ______/______/______ (Mo. Day Yr.)

Spouse's employer's name: ______________ Phone No. ( ) ______________

RESPONSIBLE PARTY INFORMATION

☐ Info Same as Above

Responsible Party: ______________ Date of Birth: ______________

Relationship to Patient: Self Spouse Other ______________ Social Security # ______ - ______ - ______

Responsible party's home phone: ( ) ______________ work phone: ( ) ______________

Street Address: ______________ Apt.# ______ City: ______________ State: ______ Zip: ______

Mailing Address: ______________ Apt.# ______ City: ______________ State: ______ Zip: ______

Employer's Name: ______________ Phone No. ( ) ______________

PATIENT'S INSURANCE INFORMATION

(Please present insurance cards at check in so that copies can be made)

Name of Insured: ______________ Does your insurance require a referral? ______ Deductible per yr. ______

Primary Insurance Co. Name ______________

Your relationship to insured: Self Spouse Other My insurance is ☐ HMO ☐ PPO ☐ EPO ☐ Other

Insurance billing address: ______________

Insurance I.D. #: ______________ Group # ______________

City: ______________ State: ______ Zip: ______

Secondary Insurance Co. Name: ______________

Your relationship to insured: Self Spouse Other My insurance is ☐ HMO ☐ PPO ☐ EPO ☐ Other

Insurance billing address: ______________

City: ______________ State: ______ Zip: ______

Secondary Insurance I.D. #: ______________ Group # ______________

OTHER INFORMATION

Name of Physician/Friend/Directory who referred you: ____________________

Primary Care Physician: ____________________ Phone#: ____________________

Pharmacy of Choice: ____________________ Phone #: ____________________

EMERGENCY CONTACT

Name of person not living with you: ____________________ Relationship ____________________

Address: ____________________ City: ____________________ State ________ Zip ____________

Home Ph. (   ) ____________________ Wk. Phone: (   ) ____________________ Cell. Phone (   ) ____________________

ASSIGNMENT OF BENEFITS • FINANCIAL AGREEMENT

I hereby give lifetime authorization for payment of insurance benefits to be made directly to Dermatologist Medical Group of North County, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Medicare Patients: I request payment of authorized Medicare benefits be made on my behalf to Dermatologist Medical Group of North County, a Medical Corporation, and any assisting physicians for services rendered. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Date: ____________________ **Your Signature:** ____

(over)