

**PATIENT REGISTRATION INFORMATION**

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Title: \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell / Pager: \_\_\_\_\_

Email Address: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Status : Minor [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated [ ] Referred by : \_\_\_\_\_

Family Physician: \_\_\_\_\_ Pharmacy Name/Phone: \_\_\_\_\_

Name of Spouse (or Parents, if minor): \_\_\_\_\_ Employer Name/Address: \_\_\_\_\_

Best Place/Time to Reach You: \_\_\_\_\_ Employer Phone#: \_\_\_\_\_

**PAYMENT INFORMATION**

**OFFICE POLICY:** Due to the high cost of billing, payment is expected at the time of your visit or procedure, unless other arrangements have been discussed with our staff. We appreciate your cooperation in settling your account at each office visit, including any co-payments, deductibles, unpaid Medicare or insurance balances, and charges for cosmetic procedures or skin products.

**Who is responsible for payment of your account in our office?** (Circle ONE of the following)

1) Self    2) Parent    3) Spouse    (Name /Address if different than above) \_\_\_\_\_

4) Insurance Plan or HMO: (Name of Insurance Company) \_\_\_\_\_ No Insurance \_\_\_\_\_

(Policy Information / #) \_\_\_\_\_

(To help us submit any insurance claims or lab specimens accurately for optimal reimbursement to you or to our office, please present your insurance card to our reception desk for verification / validation.)

**ACKNOWLEDGEMENT & CONSENT:**

- I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care (including HIV information) to third party payors and/or other health practitioners.
- I authorize and request that my insurance company pay directly to the doctor (s) insurance benefits otherwise payable to me.
- I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to my dependents or me.
- I also understand that my insurance carrier may disallow certain diagnoses or services as medically uncovered, medically unnecessary, or cosmetic. I agree to be responsible for payment of all such services rendered to my dependents or me.

X \_\_\_\_\_  
Signature of Patient or Parent/Relation Representative      Print Name of Patient or Personal Representative      Date

- I acknowledge that I have received a copy of this office's **NOTICE OF PRIVACY PRACTICES**. I also consent to the use and disclosure of my medical information to treat me and arrange for my medical care, to seek and receive payment for the services given to me, and for the business operations of this medical office.

X \_\_\_\_\_  
Signature of Patient or Parent/Relation Representative      Print Name of Patient or Personal Representative      Date

*Please return this form to the reception desk when completed. Our staff will be glad to assist you if you have any questions.*