****

**PATIENT REGISTRATION FORM**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name | |  | | | | | | | | | | | | | | | |
|  | | Last | | | | First | | | | | | | Middle | | | | |
| Mailing Address | | |  | | | | | City |  | | | | State |  | | Zip |  |
| Street Address | | |  | | | | | City |  | | | | State |  | | Zip |  |
| Employer | | |  | | | | | | | | Work Phone | |  | | | | |
| Home Phone | | |  | | | | | | | | Date of Birth | |  | | | | |
| Age |  | | Sex |  | Marital Status | |  | | Race |  | | Social Security Number | | |  | | |

**PARENT OR RESPONSIBLE PARTY (If different from patient)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | | | | | | | | | | | | | | |
|  | Last | | | First | | | | | | | MI | | | | |
| Mailing Address | |  | | | City |  | | | | State | | |  | Zip |  |
| Street Address | |  | | | City |  | | | | State | | |  | Zip |  |
| Employer | |  | | | | | | Work Phone | | | |  | | | |
| Home Phone | |  | | | | | Date of Birth | |  | | | | | | |
| Social Security Number | | |  | |  | | | | | | | | | | |

**PLEASE PROVIDE ALL INSURANCE CARDS FOR COPYING AT TIME OF CHECK-IN.**

**IF POLICY HOLDER IS NOT THE PATIENT, PLASE FILL IN INFORMATION BELOW.**

|  |  |  |
| --- | --- | --- |
| Name of Insured |  |  |
| Insured’s Date of Birth |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| In case of emergency, who should be notified? | |  | Phone |  |
| Referred by |  | | | |
| Primary care physician |  | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Do we have 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 |  |

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, MasterCard and Visa. In the event of major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. You have also been provided with our office financial policy outlining our insurance filing and payment procedures in depth. Your signature below signifies your understanding and willingness to comply with this policy.

\*Coastal Dermatology has a 24-hour cancellation policy. Failure to cancel your appointment within this time period may result in a $25.00 charge.

|  |  |
| --- | --- |
|  |  |
| Patient or Responsible Party Signature | Date |