COASTAL
DERMATOLOGY & SURGERY CENTER, P.A.

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, PLEASE 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 & Surgery Center, P.A. has a 24-hour cancellation policy. Failure to cancel your appointment within this time period may result in a $25.00 charge. Failure to cancel a surgical appointment within this time period may result in a $150.00 charge.

_____
Patient or Responsible Party Signature Date