Dermatology & Skin Cancer Surgery Center
Patient Registration Form

(PLEASE PRINT CLEARLY) Today's Date:_______________

PATIENT INFORMATION

Patient's Last Name: _________________________ First: ___________________________ M.I.______
Mailing Address: ____
City: ________________________________ State: _________________________ Zip: ____________
Home Phone: ______-_______-_______ Cell: ______-_______-_______Work:______-_______-________
Date of Birth: _______/_______/________ Age: ________ Sex: _______ SSN: _____________________
Driver's License #:______________________________ Martial Status: ___________________________
E-Mail Address of Patient or Responsible Party: ____

RESPONSIBLE PARTY (If Different from Patient)

Last Name: ________________________________ First: ___________________________ M.I.______
Mailing Address: ____
City: ___________________________ State: ____________________ Zip: _______________________
Home Phone: ______-_______-_______ Cell: ______-_______-_______ Work: ______-_______-________
Date of Birth: ______/______/______ Sex: _________ Driver's License #:_________________________

INSURANCE INFORMATION

(Please give your Insurance Card & Driver's License to the Receptionist)

Name of Policy Holder: ________________________________ Date of Birth: ______/______/______
SSN: ____________________ Employer: ________________________ Phone #:_____/______/______
Relationship to the Patient: ____

How did you hear about us? Please check one:
Family_____ Friend_____Doctor_____Advertizing_____Insurance_____Other_____________________
If Referred by Doctor: Name: Dr.___________________________ Phone #: ______/_______/_______

I hereby consent to treatment by Dermatology & Skin Cancer Surgery Center for the care of the patient indicated on this form. 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 provider.
Payment is required for all services at the time services are rendered, unless you have an insurance plan with whom we participate. For those patients, co pay's, deductibles, and percentages **WILL BE COLLECTED**. We accept cash, checks, credit and debit cards. We charge a $20.00 service fee, if your account is placed with our collection agency for non-payment. Your signature below signifies your understanding and willingness to comply with this policy.

Do We Have Permission to:

Leave messages on your home/cell answering machine? Y or N
Leave messages at your place of employment? Y or N
Leave messages regarding biopsy or lab results? Y or N
Discuss your medical condition with any member of your household? Y or N
If Yes, Whom_____________________________________ Relationship: _______________________
In Case of Medical Emergency, who should be notified? ____________________________________
Relationship: ____ Phone #:_____/_______/________

Signature of Patient OR Responsible Party ____