REGISTRATION INFORMATION
PREMIERE DERMATOLOGY AND SURGERY
(PLEASE PRINT)

Date: ______________________ Home Phone: ____________________ Cell: ______________________

Patient: ____
Last Name First Name Middle Initial
Street Address: ____

City: _______________ State: ______ Zip: _________ Sex: ____ Age: _____ D.O.B: ___________

Email _________________ Marital Status : Single _____ Married _____ Divorced _____ Widowed _____

Patient/Parent Employed By: ___________________________ Occupation: ___________________________

Business Address: ______________________________________ Business Phone: ____________________

Purpose of Visit: ____________________________________. How long has this condition existed? ___________

Policy Holder's Name _______________________ Relationship __________ D.O.B. _______SSN: __________

Patient/Parent's Social Security # _____________________ Spouse's Social Security # _____________________

Do you have Medical Insurance? _____ No _____ Yes
Name of Primary Insurance ______________________ Name of Secondary Insurance (if any) _______________
In case of emergency, please notify: ____
Relationship to patient: _________________ Telephone: _________________Work/Cell number: _____________

How did you hear about us? Provider Handbook (which) _____________ Advertising Source _______________

Yellow Pages (which) __________ Internet _________ Referring Physician _______________________________

Address ____ Phone ________________________

In order for your insurance information to be processed, we will require a copy of a federally-issued photo I.D.

Assignment of Insurance Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I ____________________________________ hereby authorize ____
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to Premiere Dermatology & Surgery, L.L.C. all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Premiere Dermatology & Surgery, L.L.C. will be credited to my account, in accordance with the above assignment. A $30 returned check fee is charged on all returned checks.

____ ___________________________________
(Authorized Signature of Insured) (Date)

Please initial that you understand that you may be seen by a Physician Assistant ________________.
Please note that there is a $25 charge for all **No Show** patients and patients not allowing 24-hr cancellation notice.