PATIENT REGISTRATION

Date: _____ Patient's Name: _____
(NAME AS IT APPEARS ON YOUR INSURANCE CARD)

Address: _____
(Street) (Apt. #) (City) (State) (Zip)

Home#_____ Cell#: _____ Work#: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Marital Status: M W D S (Please Circle One) Sex: Male or Female (Please Circle One)

Email Address:_____ Employer:_____
(If un-able to reach you by phone)

Race _____ Ethnicity: Hispanic □ Non-Hispanic□ Preferred Language: _____

Referred by: _____ How'd You Hear About Us? _____

Family Physician: _____

INSURANCE AND RESPONSIBLE PARTY INFORMATION

Primary Insurance Co: _____ID#: _____

Subscriber's Name:: _____ Subscriber's Date of Birth: _____

Subscriber's Address (if different from above): _____

Subscriber's Social Security # _____ Subscriber's Employer _____

Relationship to patient _____

Secondary Insurance Co: _____ID#: _____

Subscriber's Name:: _____ Subscriber's Date of Birth: _____

Subscriber's Address (if different from above): _____

Subscriber's Social Security # _____ Subscriber's Employer _____

Relationship to patient _____

Tertiary Insurance Co: _____ID#: _____

Subscriber's Name:: _____ Subscriber's Date of Birth: _____

Subscriber's Address (if different from above): _____

Subscriber's Social Security # _____ Subscriber's Employer _____

Relationship to patient _____

Patient's Name: _____ **DOB**: _____

Reason for Visit: _____ Duration of symptoms: _____

(Please be Specific)

Pharmacy: _____**Pharmacy Phone and address**: _____

Referring Doctor: _____ Family Doctor:_____

PLEASE CHECK ALL THE PROBLEMS THAT APPLY TO YOU:

PERSONAL HISTORY:

Occupation: _____

__ Smoke _____ Amount _____

__ Blood Transfusion Year _____

__ Tested for HIV Year and Result: _____

MEDICATIONS NOW TAKING (Include over The counter medications and aspirin)

Type: Dose:

_____

_____

_____

I have ALLERGIES to the following MEDICATIONS:

_____

_____

_____

Have you been diagnosed with:

___ Malignant Melanoma

___ Other Skin Cancer

PAST HISTORY:

MEDICAL PROBLEMS:

___ Diabetes

___ Cancer Types: _____

___ Anemia

___ Arthritis

___ Stomach/Bowel Problems

___ High Blood Pressure

___ Heart Problems

___ Thyroid Problems

___ Urinary Problems

___ Hepatitis

___ Liver Problems

___ Neurologic Disorders Type: _____

___ Asthma

___ Lupus or other collagen vascular disease

___ High Cholesterol

___ Other: _____

Has anyone in your family been diagnosed with:

___ Malignant Melanoma

___ Other Skin Cancer

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE… I authorize the release of any medical or other information necessary to process claims. I also request payment of government benefits either to myself or the party who accepts assignment.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE… I authorize payment of medical benefits to the physician or supplier for services rendered.

AGREEMENT TO BE FINANCIALLY RESPONSIBLE: I/We, _____ (guarantor) agree to be financially responsible for the cost of all medical services rendered to the patient by Coastal Dermatology. If payment for these services is not made when requested, I agree to pay, in addition to the physician's fee, all costs of collecting the amount due. I understand that my insurance will be filed for me as a courtesy and that I will be responsible for payment of any amount not paid by the insurance company because of deductible, co-insurance, lapse of coverage or cancellation of coverage. If you have insurance coverage with a company with whom we do participate, you will be asked to pay for the cost of the office visit on the day of service. We will file your insurance claim for you so that you will receive your reimbursement.

I understand that Coastal Dermatology will charge my account $35.00 for any "No Show" appointments or Cancellations within 24 hours.

_____ _____

(Signature) (Date)

Office use only:_____