

CAROLINA DERMATOLOGY PATIENT REGISTRATION

PATIENT INFORMATION

(Please Print)

Today's Date ___/___/___

Name _____
Last First MI

Mailing Address _____
Street City State Zip

SS# _____ Date of Birth ___/___/___ Age _____ Sex _____

Home Phone (____) _____ Work Phone (____) _____ Marital Status _____

Employer _____ Address _____
(If Minor or if in College, Name of School)

INSURANCE INFORMATION (Please present insurance card at time of check in)

Primary Insurance Name _____
Name of Insured _____
Insured SS# _____
Insured DOB _____
Insured's ID# _____
Group # _____
Employer Name _____
Employer Address _____

Secondary Insurance Name _____
Name of Insured _____
Insured SS# _____
Insured DOB _____
Insured's ID# _____
Group # _____
Employer Name _____
Employer Address _____

Employer Phone (____) _____
Patient Relationship to Insured _____

Employer Phone (____) _____
Patient Relationship to Insured _____

Parent or Responsible Party (if different from pt.) **Name** _____

Address _____
Street City State Zip

Other Family members that are patients _____

Referred by: _____

Pharmacy of Choice _____ Phone (____) _____

Primary Care Physician _____ Phone (____) _____

In case of emergency notify _____ Phone (____) _____

I authorize the release of medical information to my primary care/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 Carolina Dermatology and/or the physician.

Patient or Responsible Party Signature _____ Date ___/___/___

Payment is required for all services at the time they are rendered unless you are in an insurance plan with which we participate. For those patients applicable copayments will be collected when services are rendered or there will be a \$10.00 charge to offset mailing expenses. We accept payment in the form at cash, check, Visa, Or MasterCard. In the event your account must be turned over to collections, a \$25.00 collection fee will be added to your account. For appointments which are missed or cancelled with less than 24 hour notification there will be a \$25.00 missed appointment fee added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _____ Date ___/___/___

Copy of Insurance Card (both sides) attached.

Power of Attorney on file.