ClearSkin Dermatology
general · cosmetic · pediatric

PATIENT REGISTRATION FORM

Name: _____

Date of Birth: _____/_____/_____ SSN: _____-_____-_____ Gender: _____

Address: _____

Home Phone: (___) _____-_____ Cell: (____) _____-_____ Work: (___) _____-_____

Email Address: _____

Ethnicity: _____ Marital Status: _____ First language: _____

*Pharmacy Preferred: _____

*Address of Pharmacy/Phone number: _____

Primary Care Physician: _____ PCP Phone #: (_____)_____-_____

HMO INSURANCE PLANS

I understand that I may have an obligation to obtain a referral from my Primary Care Physician prior to making an appointment. I acknowledge that if I do not have a required referral for today's visit, I am responsible for the services rendered should this be denied by my insurance company.

Signature: _____ Date: _____

EMERGENCY CONTACT / SPOUSE / GUARDIAN

Name:_____

Address: _____

Home Phone: (___) _____-_____ Cell Phone: (___) _____-_____ Work Phone: (___)_ ____-_____

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PRIMARY INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____

Policy Number/Member ID: _____

Group Number: _____

Policy Holder's DOB: _____/_____/_____ Policy Holder's Phone: (_____) _____ - _____

SECONDARY INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____

Policy Number/Member ID: _____

Group Number: _____

Policy Holder's DOB: _____/_____/_____ Policy Holder's Phone: (_____) _____ - _____

CONSENT TO TREAT AND PAYMENT AUTHORIZATION

With my signature below, I voluntarily give consent for myself and/or my child to be examined and treated by the clinicians of **ClearSkin Dermatology**. I also hereby assign and authorize payment of medical benefits to **ClearSkin Dermatology** and payments may be made on my behalf directly for services rendered.

Signature: _____ Date: _____

Phone: (407) 866-1213 / Fax: (407) 866-1181