

# Town Square Dermatology Patient Registration Form

## Patient Information – 2010

SSN#: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Sex  M  F  
*First Middle Last*

Prefer to be called: \_\_\_\_\_ Title:  Mr.  Mrs.  Ms.  Miss  Dr.

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_ Employer: \_\_\_\_\_  
*Month Day Year*

Address: \_\_\_\_\_  
*Street # Street Name Apt #*

\_\_\_\_\_ *City State Zip*

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
*Area code Area Code Area Code*

Which phone would you prefer us to call? Home  Work  Cell

## Parent or Responsible Party (if different from patient)

Name: \_\_\_\_\_ Sex  M  F  
*First Middle Last*

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Employer: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ SSN# \_\_\_\_\_  
*Area code Area Code*

## Insurance Information (Please present insurance card at time of check-in)

### Primary Insurance

Ins. Name \_\_\_\_\_  
Ins. Address \_\_\_\_\_  
Name of Insured \_\_\_\_\_  
Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Insured's ID# \_\_\_\_\_  
Group# \_\_\_\_\_  
Employer Name \_\_\_\_\_  
Relationship of patient to insured \_\_\_\_\_

### Secondary Insurance

Ins. Name \_\_\_\_\_  
Ins. Address \_\_\_\_\_  
Name of Insured \_\_\_\_\_  
Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Insured's ID# \_\_\_\_\_  
Group# \_\_\_\_\_  
Employer Name \_\_\_\_\_  
Relationship of patient to insured \_\_\_\_\_

Who referred you? \_\_\_\_\_ Pharmacy of Choice: \_\_\_\_\_

Do we have your permission to:

	Yes	No
Leave a message on your answering machine at home?	<input type="checkbox"/>	<input type="checkbox"/>
Leave a message at your place of employment?	<input type="checkbox"/>	<input type="checkbox"/>
Discuss your medical condition with any member or your household?	<input type="checkbox"/>	<input type="checkbox"/>

If yes, whom? \_\_\_\_\_ Relationship \_\_\_\_\_

× \_\_\_\_\_  
*Signature of Patient or Responsible Party*

\_\_\_\_\_  
*Date*

**-Over-**

**\*\*Please Sign This Side Of Form At The Time Of Registration\*\***

*I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance application and prescriptions. I also authorize payment of medical benefits to the physician.*

× \_\_\_\_\_  
Signature of patient or responsible party Date

**Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations**

I understand that as part of my healthcare *Town Square Dermatology* originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health care professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided

I understand and have been provided with a **Notice of Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notices prior to signing this consent. I understand that the *Town Square Dermatology* reserves the right to change their notice and practices prior to implementation. I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that *Town Square Dermatology* is not required to agree to the restriction requested. I understand that I may revoke this consent in writing.

**I request the following restrictions to the use or disclosure of my health information:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of patient or responsible party: × \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. **Payment is expected from you at the time of service for your part of the charges. We accept cash, check, Visa, Mastercard, American Express and Discover for your convenience.** Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when assigned claim is filed. In the event that your account must be turned over to collections a \$10.00 collection fee will be added to your account.

× \_\_\_\_\_  
Signature of patient or responsible party Date