Please Print

Clear Skin Dermatology
Registration Information

Account #_____
(Office use only)

I. Patient Information

Legal Name: (Last) _____ (First) _____ (MI) _____

Sex: ❑ Male ❑ Female Birthdate: ____/____/____ Marital Status: _____
MM / DD / YYYY

Home Address: _____

City/State/Zip: _____ Unit#: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ @ _____

Employer: _____ Occupation: _____

Race:
❑ Asian ❑ African American
❑ Black Non-Hispanic ❑ Hispanic
❑ Pacific Islander ❑ Native American
❑ White Non-Hispanic ❑ Other _____

Ethnicity:
❑ Latino/Hispanic
❑ Other _____
❑ Do not want to report
Preferred Language: _____

Referred by a physician? ❑ Y ❑ N Physician Name: _____

How did you hear about us? _____

In Case Of Emergency Call:

Name: _____ Phone: _____ Relationship: _____

II. Guarantor Information (Parent or person responsible for account)

Legal Name: _____

Relationship to Pt: _____ Birthdate: _____ Sex: ❑ Male ❑ Female

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

III. Primary Insurance Information

Policy Holder Name: _____ Birthdate: _____ Relationship to patient: _____

Insurance Name: _____ **A copy of your insurance card will be taken at the office.

Address: _____ City/State/Zip: _____

IV. Secondary Insurance Information

Policy Holder Name: _____ Birthdate: _____ Relationship to patient: _____

Insurance Name: _____ **A copy of your insurance card will be taken at the office.

Address: _____ City/State/Zip: _____

CLEAR SKIN DERMATOLOGY & COSMETIC SURGERY

Consent for Treatment / Assignment of Benefits / Notice of Privacy Practices
Consent for Confidential Communication / Protected Health Information

Consent for Diagnosis and Treatment

I understand that by presenting myself for healthcare services at Clear Skin Dermatology & Cosmetic Surgery (CSD), I consent to and authorize the administration and performance of all treatments and tests, after being fully informed and agreeing there to,which may be ordered by the physicians (and/or designated assistant) and carried out by any member of Clear Skin Dermatology staff and other personnel I acknowledge that Clear Skin Dermatology may photograph me for the purpose of assisting CSD personnel with recognizing, identifying and treating me, and I consent to CSD's use of the photographs for its internal purposes and no others.

Assignment of Benefits and Guarantee of Payment

In consideration of medical services provided to me by CSD, I hereby assign CSD its physicians and other professionals associated with the practice, all of my rights and claims for reimbursement under any Medicare, Medicaid, or group health insurance policy for which benefits may be available for payment of the services provided. I agree to pay CSD and the physician and other professionals associated with the practice the balance due of all charges not paid by the above-mentioned coverage (excluding those charges not collectable pursuant to insurance contracts and Medicare regulations). This may include cost of collection and/or reasonable attorney fees. I agree to provide CSD with a current, valid health insurance policy card at the time of my appointment. If no card is available, and/or my coverage is no longer active, I will be financially responsible for all services rendered, at the time of service.

Acknowledgement of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It is posted in our waiting room and you may request a copy of the notice from our front desk staff. The terms of this notice may change. If we change our notice, you may obtain a revised copy from our front desk staff.

Consent to Leave Telephone Message

I authorize Clear Skin Dermatology to leave a message containing appointment information and basic medical information, as follows. (I understand that if no selection is made, detailed phone messages will not be left):

Please select your prefered contact number. **Is it ok to leave a detailed message?**

❒ Contact me at my home. Phone#_____ ❒ Yes ❒ No

❒ Contact me on my cell phone. Phone#_____ ❒ Yes ❒ No

❒ I would like to receive cell phone text reminders, for my appointments.

❒ Contact me at work. Phone#_____ ❒ Yes ❒ No

Consent for Young Adult Patients (18-26 years of age)

❒ I authorize Clear Skin Dermatology to discuss medical information with family members designated as follows:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Consent for Adult Patients

❒ I authorize Clear Skin Dermatology to discuss medical information with family members designated as follows:

Name:_____ Relationship:_____

I have read each of the above paragraphs and fully agree to each of the statements. I acknowledge my agreement by signing below.

_____ _____
Patient Date

_____ _____
Parent or Guardian (if patient is under 18 years of age) Date

_____
Print Name