INTEGRATED DERMATOLOGY GROUP

REGISTRATION INFORMATION

PATIENT INFORMATION **DATE:**

LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #	
MAILING ADDRESS		CITY	STATE	ZIP	SEX ☐ MALE ☐ FEMALE
HOME #	WORK #		EMAIL ADDRESS		
MOBILE #	SPOUSE'S NAME		MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED		

RESPONSIBLE PARTY INFORMATION (If other than self)

LAST NAME	FIRST	MI	HOME #	
ADDRESS	CITY	STATE ZIP	SOCIAL SECURITY #	
EMPLOYER	OCCUPATION		WORK #	
EMPLOYER'S ADDRESS	CITY	STATE ZIP	RELATIONSHIP TO RESPONSIBLE PARTY ☐ SPOUSE ☐ SON ☐ DAUGHTER	
MOTHER'S NAME	MOTHER'S BIRTHDATE	FATHER'S NAME	FATHER'S BIRTHDATE	

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT	OCCUPATION	EMPLOYMENT OR STUDENT STATUS:
PATIENT'S EMPLOYER'S OR SCHOOL ADDRESS		☐ FULL-TIME ☐ NOT EMPLOYED
CITY STATE ZIP		☐ SELF EMPLOYED ☐ PART-TIME
		☐ ACTIVE MILITARY ☐ RETIRED

EMERGENCY INFORMATION

NAME	RELATIONSHIP	HOME #	
ADDRESS	CITY STATE ZIP	CELL #	

HIPAA MEDICAL RELEASE ☐ **CHECK IF SAME AS EMERGENCY CONTACT**

NAME	RELATIONSHIP	NAME	RELATIONSHIP

PHARMACY NAME

PRIMARY CARE PHYSICAN

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

I hereby authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance, and other health plans to Integrated Dermatology of Gloucester, LLC of any medical benefits payable to me for the services provided at Integrated Dermatology of Gloucester, LLC. I also authorize the release of all medical information necessary to process insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claims processing or as long as dictated by payer. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance deemed patient responsibility by the insurance company. I understand it is my responsibility to pay the balance in full if the insurance information provided proves false or otherwise ineffective. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

I also understand that if I do not cancel my appointment within 24 hours of my appointment time I am subject to a $25.00 fee for office visits and $50.00 fee for surgical or cosmetic visits.

X _____

Patient Signature or Signature of Guardian or Parent Date

MEDICARE PATIENTS ONLY - Lifetime Signature on File and Lifetime Consent

I request that payment of authorized Medicare benefits be made on my behalf to Integrated Dermatology of Gloucester, LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services. I request that payment of authorized Medigap or secondary insurance benefits be made on my behalf to Integrated Dermatology of Gloucester, LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

X _____

Patient Signature Date