

**REGISTRATION INFORMATION**

**PATIENT INFORMATION** **DATE:**

LAST NAME	FIRST NAME	MI	BIRTHDATE	SOCIAL SECURITY #	
MAILING ADDRESS			CITY	STATE	ZIP
PREFERRED PHONE #			EMAIL ADDRESS		
ALTERNATE PHONE #	SPOUSE'S NAME			MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	
<b>RESPONSIBLE PARTY INFORMATION (If other than self)</b>					
LAST NAME			FIRST		MI
ADDRESS			CITY	STATE	ZIP
EMPLOYER			OCCUPATION		WORK #
EMPLOYER'S ADDRESS			CITY	STATE	ZIP
MOTHER'S NAME			MOTHER'S BIRTHDATE	FATHER'S NAME	
				FATHER'S BIRTHDATE	

<b>RESPONSIBLE PARTY INFORMATION (If other than self)</b>					
LAST NAME			FIRST		MI
ADDRESS			CITY	STATE	ZIP
EMPLOYER			OCCUPATION		WORK #
EMPLOYER'S ADDRESS			CITY	STATE	ZIP
MOTHER'S NAME			MOTHER'S BIRTHDATE	FATHER'S NAME	
				FATHER'S BIRTHDATE	

<b>EMPLOYMENT INFORMATION</b>					
PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT			OCCUPATION		EMPLOYMENT OR STUDENT STATUS: <input type="checkbox"/> FULL-TIME <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> SELF EMPLOYED <input type="checkbox"/> PART-TIME <input type="checkbox"/> ACTIVE MILITARY <input type="checkbox"/> RETIRED
PATIENT'S EMPLOYER'S OR SCHOOL ADDRESS					
CITY		STATE	ZIP		

<b>EMERGENCY INFORMATION</b>					
NAME		RELATIONSHIP		PHONE #	
ADDRESS		CITY		STATE	ZIP

**PHARMACY NAME**

**PRIMARY CARE PHYSICIAN**

**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