4715 Valley East Blvd., Suite 3 • Arcata, Ca 95521
(707) 822-3376 (707)822-5053 Fax

1575 South Railroad Ave. • Crescent City, Ca 95531
(707)464-8335 (707)464-8339 Fax

PATIENT REGISTRATION FORM

LEGAL Name(Last)_____(First)_____(M.I.)_____

Prefix_____Suffix_____NickName_____

Parent/Guardian Name(if minor)_____

Please circle one: Married Single Widowed Minor Other

Social Security#:_____-_____-_____**Date Of Birth**:_____/_____/_____Sex: M F

Language:_____Preferred Contact Method: Phone Patient Portal Email

Race:_____Ethnic Group:_____

CONTACT INFORMATION

Emergency Contact
Full Name_____Phone#_____

Spouse Full Name_____Phone#_____

Caretake Full Name_____Phone#_____

PHONE NUMBERS

Home Phone#_____Work#_____Mobile #_____

Preferred Phone: Home Work Mobile Is it okay to leave a detailed message? Y N

* EMAIL ADDRESS:_____

ADDRESS

Mailing Address:_____

City_____State_____Zip Code_____

EMPLOYEMENT INFORMATION

Employers Name:_____

Occupation_____Industry_____

Please see reverse for more information

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 AT THE TIME OF SERVICE FOR YOUR PART OF THE CHARGES. We accept Visa and MasterCard for you convenience.

I am an eligible member of the health plan provided at the time of service. My signature below acknowledges full financial responsibility for services rendered to me including all costs, if it is determined that I am not eligible on the date of service, or if services rendered are a non-covered benefit under the plan provisions.
I acknowledge there will be a $25.00 fee for all returned checks.

I am also aware that North Pacific Dermatology uses an out of the state lab(Richfield Laboratories-Ameripath in Cincinnati,OH) and it is my responsibility to make sure that my insurance covers any lab charges that may incur.

My signature below indicates that I understand and accept this policy and that the information I have provided is accurate. Also, I authorize North Pacific Dermatology to release such medical information necessary to process my insurance claim(s). I hereby authorize payment of medical benefits to: North Pacific Dermatology when assigned claim in filed.

If policy holder is different from the patient:

Cardholder's Name:_____

Relationship to Patient:_____Date of Birth_____/_____/_____

I give consent to call me at my place of employment: Yes No

I give consent to leave a message and/or discuss my medical conditions, including clinical care and lab results, with a member of my household: Yes No
If yes, whom:_____Relationship_____

X_____
SIGNATURE OF PATIENT(OR GUARDIAN) **DATE**

My signature verifies that all information provided on the front and back of this document is true to the best of my knowledge and has been read and understood.