PATIENT REGISTRATION FORM

TODAYS DATE: ____________________ **EMAIL ADDRESS:** ________________________

TITLE: ❑MR. ❑ MRS. ❑ MISS. ❑ MS. **MARITAL STATUS:** ❑MARRIED ❑SINGLE ❑DIVORCED ❑WIDOWED ❑OTHER

PATIENTS LAST NAME: ____________________________ **FIRST NAME:** ____________________________ **MIDDLE INITIAL:** ______

DATE OF BIRTH: _____/_______/_________ **AGE:** ____________________ **SEX:** ❑ MALE ❑ FEMALE

STREET ADDRESS: ____

CITY: ____________________ **STATE:** ____________________ **ZIP CODE:** ____________________

HOME PHONE: ____________________ **CELL PHONE:** ______________________ **WORK PHONE:** ____________________

OCCUPATION: ____ **EMPLOYER:** __________________________________

PHARMACY NAME: _________________________________ **PHARMACY PHONE NUMBER:** ___________________________

PHARMACY ADDRESS: ____

HOW DID YOU HEAR ABOUT THE PRACTICE:

❑FAMILY ❑FRIEND ❑ CLOSE TO WORK/HOME ❑ INSURANCE ❑ DOCTOR ❑OTHER

RACE: ❑ASIAN ❑ WHITE/CAUCASIAN ❑BLACK OR AFRICAN-AMERICAN ❑AMERICAN INDIAN OR ALASKA NATIVE

❑NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ❑MULTI-RACIAL ❑OTHER RACE ❑ PREFER NOT TO ANSWER

ETHNICITY: ❑HISPANIC OR LATINO ❑ NON HISPANIC OR LATINO ❑PREFER NOT TO ANSWER

(STATE AND LOCAL GOVERNMENTS MAY USE THE DATA TO HELP PLAN AND ADMINISTER BILINGUAL PROGRAMS FOR PEOPLE OF HISPANIC ORIGIN)

PATIENTS PREFERED LANGUAGE: ____

INSURANCE INFORMATION

PRIMARY INSURANCE: ❑ BLUE CROSS BLUE SHIELD ❑BLUE CHOICE ❑MEDICARE ❑UNITED HEALTHCARE ❑OTHER

PRIMARY POLICY HOLDER'S NAME: ____

DATE OF BIRTH: _______/_______/________

POLICY NUMBER: _______________________________________ **GROUP NUMBER:** ___________________________

PATIENTS RELATIONSHIP TO PRIMARY POLICY HOLDER: ❑SELF ❑SPOUSE ❑CHILD ❑OTHER

RELEASE OF INFORMATION

I HEREBY AUTHORIZE ELK GROVE DERMATOLOGY TO RELEASE INFORMATION CONCERNING MY MEDICAL CARE TO THE FOLLOWING:

NAME:__________________________________ **RELATIONSHIP:** _______________________________ **NUMBER:** ________________________

NAME:__________________________________ **RELATIONSHIP:** _______________________________ **NUMBER:** ________________________

IN CASE OF EMERGENCY PLEASE NOTIFY

NAME: ______________________________________ **RELATIONSHIP:** _________________ **NUMBER:** __________________

AGREEMENTS AND AUTHORIZATION

CONSENT TO HEALTHCARE SERVICES

- I, (the Patient signing below, or person signing below who is responsible for consenting on Patient's behalf) request and consent to all care, treatment, and other services that may be ordered, requested, directed, or provided by physicians, or their associates, assistants, or designees, and carried out by physicians or personnel at Elk Grove Dermatology.
- I understand that I have the right to refuse this care, treatment or other services, as long as refusal is allowed under the law.
- I understand that the practice of medicine is not an exact science. I understand and agree that no guarantees have been made, or can be made, as to the result of diagnosis, treatments and medications, tests or examinations provided at Elk Grove Dermatology.

RECEIPT OF NOTICE OF PRIVACY PRACTICE

- I acknowledge that I have been offered and read a copy of Elk Grove Dermatology's Notice of Privacy Practices. The Notice of Privacy Practices describes how the Patient's medical information may be used and disclosed by Elk Grove Dermatology and describes the Patient's rights with respect to this medical information.

PAYMENT GUARANTEE

- I acknowledge that I have been offered and read a copy of Elk Grove Dermatology's Payment guarantee.
- In consideration of the services provided by Elk Grove Dermatology to Patient, I agree to: 1) guarantee payment of all charges that are related to the services provided to the Patient; 2) for all time assign and transfer to Elk Grove Dermatology all of the Patient's right, title and interest to medical reimbursement benefits that are available to pay for those charges; and 3) authorize payment of these benefits directly to Elk Grove Dermatology.
- I agree that Elk Grove Dermatology is not responsible for finding out if the Patient has any insurance or other benefits that may pay for care or services provided to the Patient, or what the extent of the Patient's benefits may be.
- I agree to be fully responsible for the payment of any and all charges if these charges are not covered by the assigned benefits.
- Elk Grove Dermatology provides many services to assist uninsured patients as well as patients who cannot afford the cost of care. I understand that if I have any questions about Elk Grove Dermatology's financial assistance policy I may ask the office supervisor during the registration process.

APPOINTMENT CANCELLATION NOTICE

- **If you are unable to keep your appointment, you must call our office 24 (twenty-four) hours before your appointment to cancel or reschedule. Failure to call the office within 24 (twenty-four) hours will result in a $20.00 Fee.**

I acknowledge that I have read the financial policy online or at office registration, as well as the agreements and authorizations listed above. The information I have provided is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Elk Grove Dermatology or insurance company to release any information required to process my claims.

PATIENT OR GUARDIAN SIGNATURE: ____

DATE: _____/_____/_____