ClearSkin Dermatology

general + pediatric + cosmetic

Patient Registration Form

Name: ____

Date of Birth: ______/______/______ Marital Status: _________ Last 4 of Social Security #: ______

Address: ____

Home Phone: (____) ______-______ Cell: (____) _______-_______ Work: (____) ______-______

Email Address: ____

*Preferred pharmacy with phone number & zip code: __________________________________

Primary Care Physician: ____________________________ PCP Phone #: (____) ______-________

HMO REFERRAL REQUIREMENT

I understand that if I have an **HMO** plan I may have an obligation to obtain a referral from my Primary Care Physician prior to making an appointment. I acknowledge that if I do not have the required referral for today's visit, I am responsible for payment of the services rendered if it is denied by the insurance company.

Signature: ____ Date: ________________

EMERGENCY CONTACT

Name: ____

Address: ____

Home Phone: (_________) __________-__________ Cell: (_________) ___________-__________

PRIMARY INSURANCE INFORMATION

Primary Insurance: ____

Policy Holder's Name: ____

Policy Number/Member ID #: ____

Group Number: ____

Policy Holder's DOB: _______/_______/_______ Policy Holder's Phone: (_____) ______-______

SECONDARY INSURANCE INFORMATION

Secondary Insurance: ____

Policy Holder's Name: ____

Policy Number/Member ID #: ____

Group Number: ____

Policy Holder's DOB: _______/_______/_______ Policy Holder's Phone: (_____) ______-______

CONSENT TO TREAT AND PAYMENT AUTHORIZATION

With my signature below, I voluntarily give consent for myself and/or my child to be examined and treated by Dr. Sima Jain. I authorize my insurance company to pay for benefits directly to **ClearSkin Dermatology** and I agree that a reproduced copy of this authorization will be valid as the original. I understand that I am responsible for any amount not covered by my insurance or any amount for a patient whom I am the guarantor. I also agree that I will be responsible for any collection agency or attorney fees incurred. Lastly, I am giving written consent for the use and disclosure of protected health information for treatment, payment, and health care operations with my signature below.

Signature: ____________________________________ Date: ________________