THE DERMATOLOGY CENTER OF INDIANA

## Patient Registration Form

**PersonalInformation:**

Name: _____ ☐ Jr. ☐ Sr.
First Middle Last

Address : _____
Street # Street Name Apt#

_____
City State Zip Code

Home Phone: (_____)_____ Other Phone: (_____)_____ ☐ Cell ☐ Pager

MARITAL STATUS
☐ S ☐ M. ☐ D ☐ W

Date Of Birth _____/_____/_____ **SSN #** _____
Month Day Year

EMPLOYMENT STATUS
☐ Employed ☐ Unemployed ☐ Retired ☐ Other

Sex: ☐ Male. ☐ Female Occupation : _____

Employer: _____
Name Address

_____
City State Zip Code Telephone #s (with Area Code)

**Insurance Information**:

**Primary** Insurance Name: _____

Name of Insured / Policy Owner : _____**Date of Birth:**_____/_____/_____

Patient's relationship to Policy Owner: ☐ self ☐ Child ☐ Other _____

Insured's ID# and **SSN#** _____ Group # and Name _____

**Secondary** Insurance Name (if applicable) : _____

Name of Insured / Policy Owner : _____ **Date of Birth:**_____/_____/_____

Patient relationship to Policy Owner: ☐ self ☐ Child ☐ Other _____

Insured's ID# and **SSN#** _____ Group # and Name _____

Insured's Employer (if not on insurance card): _____ Name

_____
Address City State Zip Code Telephone #s (with Area Code)

**Medical Emergency Contact Information:**

Name of an individual not living with you: Relationship: _____

_____

Telephone Number: _____
Daytime Evening

What Physician referred you, if any? _____

Primary Care Physician: _____

**(over)**

Race: □ Caucasian □ African-American □ Asian □ Other If a student, School: _____

Who referred you? □ Doctor (noted above) □ Yellow Pages □ Advertisement
□ Other Person or Patient: Please list_____

Pharmacy of Choice _____ phone # (with Area Code) _____

Is this illness due to an automobile accident? _____ Date of accident:_____

Is this illness due to an injury at work? _____ DATE OF INJURY:_____

Can we leave a message with medical information on your telephone voice mail? □ Yes □ No

**X** _____ _____
Signature of Patient or Legal Guardian Date

CONSENT TO TREAT SIGNATURE:
BY SIGNING THIS FORM, I AUTHORIZE THE PHYSICIANS, AGENTS, AND EMPLOYEES OF THE DERMATOLOGY CENTER OF INDIANA TO PROVIDE MEDICAL OR SURGICAL CARE AND SERVICES, INCLUDING, BUT NOT LIMITED TO, DIAGNOSTICS TEST, EXAMINATIONS, AND OTHER MEDICAL AND SURGICAL PROCEDURES, IN THE COURSE OF MY MEDICAL CARE, AND I AGREE TO COMPLY WITH THE PLAN OF CARE/SERVICES TO WHICH I HAVE CONSENTED.

**X**_____ _____
Signature of Patient or Legal Guardian Date

INSURANCE BILLING SIGNATURE:
Your signature below indicates that the information that was provided is to the best of your knowledge, true and accurate. Further, your signature authorizes The Dermatology Center of Indiana, PC to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to The Dermatology Center of Indiana, PC when an assigned claim is filed.

**X** _____ _____
Signature of Patient or Legal Guardian Date

MEDICARE SIGNATURE:
This office is required to keep your signature on file authorizing us to file Medicare for you and to release information to that payor if they require it for proper consideration of a claim. Please read and sign the following statement: I authorize any holder of medical or other financial information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignments. Regulations pertaining to Medicare assignment of benefits apply.

**X** _____ _____
Signature of Patient or Legal Guardian Date

If you have a supplemental policy and it is a Medigap policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file" I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above Medigap carrier any information needed to determine these benefits or the benefits payable for related services.

**X** _____ _____
Signature of Patient or Legal Guardian *Date*