

DORSET STREET DERMATOLOGY, LLC

Patient Registration Form

THIS SECTION MUST BE COMPLETED BY ALL PATIENTS:

Today's Date: _____

Name (Last, First, MI): _____

Date of Birth: _____ Age: _____ Social Security #: _____ Gender: _____

Mailing Address: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Email: _____ Preferred method of contact: Home Work Cell phone E-mail

Marital Status: Single Married Divorced Widowed Separated Other

Race* _____ Ethnicity* _____ Language* _____

**Required for US Government Reporting*

Employer: _____

Emergency Contact: _____ Phone: () _____

RESPONSIBLE PARTY (if different from patient) – *MUST BE COMPLETED IF PATIENT IS A MINOR.*

Name: _____ DOB: _____

Home Phone: _____ Work Phone: _____

Did another Health Care Provider recommend that you see us today? Yes No

If YES, Please list: _____

Primary Care Physician/Name of Practice, if known: _____

How did you hear about Dorset Street Dermatology? _____

Are you interested in discussing our skin care products or rejuvenation program? Yes No

INSURANCE COVERAGE (PRIMARY):

Insurance company Name: _____

Policy #: _____ Group Name or number: _____

INSURANCE COVERAGE (SECONDARY):

Insurance Company Name: _____

Policy #: _____ Group Name or number: _____

RECEIPT OF NOTICE OF PRIVACY PRACTICES:

My signature below indicates that I have received and/or reviewed a copy of my provider’s Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.

Patient or Responsible Party Signature: _____ **Date:** _____

PAYMENT POLICY:

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual \$140.00 deductible and paying 20% co-payment. We do file with secondary / supplemental carriers. However, in the event that the secondary does not pay within the 60 days, patients will be billed the balance.

HMO, PPO or other Insurance patients: You will be responsible for paying your annual deductible, co-payment and charges for any non-covered, cosmetic services, or services rendered without a valid medical referral.

Patient or Responsible Party Signature: _____ **Date:** _____

MEDICARE PATIENTS ONLY:

The office is required to keep your signature on file authorizing is to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medical 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 assignment. Regulations pertaining to Medicare assignment or benefits apply.

Signature as it appears on Medicare Card: _____ **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.

Signature as it appears on MEDIGAP/Secondary Card: _____ **Date:** _____