ALLSKIN
DERMATOLOGY
Terri R. Dunn, M.D. Miriam Ferreira, PA-C

PATIENT REGISTRATION FORM

Thank you for choosing our office. In order to serve you properly, we will need the following information. All information is strictly confidential.

PATIENT INFORMATION – PLEASE PRINT

NAME:_____ HOME PHONE: (_____)_____

ADDRESS:_____ CITY:_____STATE_____ ZIP CODE_____

ALTERNATIVE CELL#_____ GENDER: HE/HIM SHE/HER THEY/THEIR OTHER_____

YOUR SOCIAL SECURITY #:_____ YOUR DATE OF BIRTH:_____

MARITAL STATUS: S M D W DP DRIVER'S LICENSE #:_____

EMPLOYER:_____ OCCUPATION:_____

WORK PHONE: (_____)_____EXT:_____ EMAIL:_____

RESPONSIBLE PARTY INFORMATION (IF MINOR)

RESPONSIBLE PARTY: _____ RELATIONSHIP:_____

ADDRESS:_____CITY:_____DATE OF BIRTH:_____

EMPLOYER:_____WORK PHONE: (_____)_____EXT_____

REQUIRED INSURANCE INFORMATION ***REQUIRED****

PRIMARY INSURER:_____ID#:_____GROUP#:_____

PLEASE CIRCLE: PPO AFFINITY ABMG SEBMG HILL PHYSICIANS

POLICY HOLDER:_____ DATE OF BIRTH:_____RELATIONSHIP_____

SECONDARY INSURER:_____ID#:_____GROUP#:_____

PLEASE CIRCLE: PPO AFFINITY ABMG SEBMG HILL PHYSICIANS

POLICY HOLDER:_____ DATE OF BIRTH:_____RELATIONSHIP_____

EMERGENCY CONTACT

PERSON TO NOTIFY IN CASE OF EMERGENCY:_____

RELATIONSHIP:_____HOME PHONE: (_____)_____WORK PHONE: (_____)_____

PAYMENT FOR SERVICES

I understand that it is my responsibility to confirm with my insurance carrier that this practice is a participating provider. I realize that I am financially responsible for all medical services rendered to me and or my dependents regardless of the decision involving reimbursement by my insurance carrier. I authorize AllSkin Dermatology to release any and all my information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company.

Patient signature:_____ Date:_____

For HMO patients only: I understand that I am eligible for benefits and currently enrolled with an HMO. I am aware that if the authorization above is incorrect, I am responsible for all charges related to services provided to me. I agree that if the above is not true, I will pay in full all associated charges.
I also understand that I must have an authorization from my HMO for them to pay for my visits.

Patient signature:_____ Date:_____