Schaberg dermatology

Todays Date: ____ / ____ / ____

Patient Registration Form

Patient Name: _____ **DOB:** _____ / _____ / _____ **SSN:** _____
LAST FIRST MIDDLE INITIAL

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed **Currently Employed:** ☐ Yes ☐ No

Address: _____
STREET CITY STATE ZIP CODE

Phone (*Check ☑ preferred contact number)*:

☐ Home: (____) _____ - _____ ☐ Cell: (____) _____ - _____ ☐ Work: (____) _____ - _____

E-mail: _____ *Please indicate whether we can e-mail you for an office related matter?* ☐ Yes ☐ No

Guarantor's Name: _____ **DOB:** _____ / _____ / _____ **SSN:** _____
LAST FIRST MIDDLE INITIAL

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Legal Guardian

Address: _____
STREET CITY STATE ZIP CODE

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

Insurance: *Please present your insurance card(s) with this completed form*

Primary Insurance Subscriber: _____ **DOB:** _____ / _____ / _____

Insurance Company: _____ **Group #:** _____ **Member ID:** _____

Secondary Insurance Subscriber: _____ **DOB:** _____ / _____ / _____

Insurance Company: _____ **Group #:** _____ **Member ID:** _____

Emergency Contact

1. Name: _____ **Phone:** (____) _____ - _____ **Relationship:** _____

2. Name: _____ **Phone:** (____) _____ - _____ **Relationship:** _____

Release of Information to Designated Family Member or Caregiver

The undersigned consents to Schaberg Dermatology releasing his/her medical information to:

_____ _____
Name to Receive Info Relationship to Patient

_____ _____
Name to Receive Info Relationship to Patient

_____ _____
Name to Receive Info Relationship to Patient

This consent in effect for one (1) year period (as signed by the designee.) This form must be resigned at the years expiration. This consent may be revoked at any time by the patient upon written request to the practice.

_____ _____
Patient's Signature Date

I, the undersigned, affirm that the information I have given is correct to the best of my knowledge. I authorize treatment of the person named as "patient." I hereby assign all medical/surgical benefits to which I am entitled from private insurance and any other health plan to the doctor. I understand that Schaberg Dermatology will file with my primary insurance company for service rendered, and I authorize payment of medical insurances benefits directly to Schaberg Dermatology. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I hereby authorize Schaberg Dermatology to release all information necessary to secure the payment. I also authorize Schaberg Dermatology to obtain or release any information that is related to the treatment of the "patient." A photocopy or scanned image if this authorization shall be considered as effective and valid as the original document.

_____ _____
Patient's Signature Date