

PATIENT REGISTRATION FORM

Date \_\_\_\_\_

Name \_\_\_\_\_ Prefer to be called \_\_\_\_\_

Street Address \_\_\_\_\_ Marital Status  M  W  S  D

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Referred By \_\_\_\_\_

Do you want a letter to be sent to your referring doctor?  Yes  No

Do we have your permission to:

Leave a message on your answering machine at home?  Yes  No

Leave a message at your place of employment?  Yes  No

Discuss your medical condition with any member of your household?  Yes  No

If yes, whom \_\_\_\_\_ Relationship \_\_\_\_\_

Parent/Guardian / Emergency Contact

Name \_\_\_\_\_ Prefer to be called \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

Parent/Guardian Authorization Treatment of Minor

Since my minor child \_\_\_\_\_, will be coming to the office for regular treatment of his/her dermatologic condition unaccompanied by me, I authorize Dr. Kuriata and his employees to examine, evaluate and render treatment for my child. I understand that no surgical procedure will be rendered without further discussion and informed consent.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

Please present insurance cards to the receptionist so copies can be made.

### Insurance and Payment Policy

We participate with many insurance companies. We automatically file forms for those companies. The ultimate responsibility, however, remains with the patient. We are happy to help you with insurance questions and with claim filing for companies with which we do not participate.

### Payments

Due to increased billing costs, and in an effort to contain overall cost of medical care, *we request payment at the time of service.*

For participating insurances, this includes copays for HMO and PPO companies, unmet calendar-year deductibles, *copayments* on 80/20 and 90/10 policies, and non-covered services.

For non-participating insurances, *payment is due at the time of service.* We accept payment in the form of cash, check, or credit card.

I have hereby read and understand the above Insurance and Payment Policy and agree to the contents herein.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

### Primary Insurance to File

Policy# \_\_\_\_\_ Group# \_\_\_\_\_

**Insured's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insured's Social Security # or ID# \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

### Secondary Insurance to File

Policy# \_\_\_\_\_ Group# \_\_\_\_\_

**Insured's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insured's Social Security # or ID# \_\_\_\_\_

Insurance Company Name \_\_\_\_\_

Insurance Company Address \_\_\_\_\_