Alexandria ASSOCIATES IN DERMATOLOGY

PATIENT REGISTRATION FORM

PATIENT DEMOGRAPHICS:

*Name: _____ *Date of Birth (MM/DD/YY): _____

*Address: _____ Apt: _____ City: _____ State: _____ ZIP: _____

*Phone (C) : _____ (H): _____ (W): _____

*Email Address: _____

***Preferred Contact Method**: ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email

☐ I would like to **opt out** of receiving text messages regarding- my care, including appointment reminders. (if yes, please check) *

☐ Is it OK to leave a Voicemail Message if we cannot reach you? (If yes, check) *

Social Security Number: _____ Marital Status: _____ Gender: _____

Race: _____ Ethnicity: _____

PRIMARY CARE PHYSICIAN (PCP) INFORMATION:

PCP Name: _____ PCP Phone #: _____

PCP Address: _____

REFERRING PROVIDER INFORMATION:

Name: _____ Phone #: _____

Address: _____

BILLING INFORMATION: PLEASE PROVIDE YOUR INSURANCE CARD AND PHOTO ID TO RECEPTIONIST AT EACH VISIT.

*Primary Insurance Name: _____ Member ID: _____

Policy Holder Name: _____ Policy Holder DOB (MM/DD/YY): _____

Policy Holder SSN: _____ Relationship to Patient: _____

Policy Holder Address (if different than patient) _____

***Does your Health Insurance Policy require a referral?** ☐ **Yes** ☐ **No**

BILLING INFORMATION CONTINUED:

***Do you have another Health Insurance Policy (i.e., Secondary Insurance)?** ☐ **Yes** ☐ **No**

If yes, please fill in the section below

Secondary Insurance Name: _____ Member ID: _____

Policy Holder Name: _____ Policy Holder DOB (MM/DD/YY): _____

Policy Holder SSN: _____ Relationship to Patient: _____

Policy Holder Address (if different than patient) _____

***EMERGENCY CONTACT INFORMATION:**

Name: _____ Relationship to Patient: _____

Address (Street, City, State, ZIP): _____

Phone (C):_____ (H): _____ (W): _____

Email Address: _____

Preferred Contact Method: ☐ Cell Phone ☐ Home Phone ☐ Work Phone

TO WHOM ARE YOU AUTHORIZING ACCESS OF INFORMATION & WHAT INFORMATION MAY BE RELEASED?

***May we discuss your medical condition with any member of your family?** ☐ **Yes** ☐ **No**

If **YES**, please provide the name and contact information for the person(s) with whom we may discuss your care:

Name: _____ Relationship to Patient: _____

Phone (C):_____ (H): _____ (W): _____

Email Address: _____

Preferred Contact Method: ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Email

WHAT INFORMATION MAY BE SHARED? (CHECK ALL THAT APPLY):

☐ Financial Information ☐ Labs/Pathology Results

☐ Breach of Information ☐ Medical Office Visit Note

We will bill your insurance company if we participate with that company. You are responsible for any & all charges that your insurance company does not cover such as deductibles, co-pays, and non-covered services, which are payable at the time of service. Parents/Guardians are responsible for payments on minor/dependent accounts. All tissue removed will be sent for pathologic examination at the discretion of your provider. I authorize for insurance payments to go directly to physician and for release of necessary medical records to the insurance company and to the billing service to receive payment. HMO Participants: In order for your insurance company to pay for your visit, it is your responsibility to obtain referrals from your primary care physician for each visit.

I have been provided with the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. My requested restrictions of use of this information are notated above. I certify that I understand the above and that the information I have given is correct to the best of my knowledge:

_____ _____

**Signature (parent/guardian if minor)* * *Date (MM/DD/YY)*