

MINOR PATIENT REGISTRATION

Note: We do not bill absent parents, the adult presenting the minor for care is the responsible party.

Name _____ Today's Date _____

Address _____ City _____ State _____ Zip _____

Sex: Male Female Student: Full Time Part Time

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

Date of Birth ____/____/____ Age _____ SS # _____ - _____ - _____

Race _____ Referring Doctor _____ How did you hear about this practice? _____

Emergency Contact _____ Relationship _____ Phone # _____

PRIMARY INSURANCE INFORMATION

Does your insurance require labs/pathology to be sent to a specific lab? No Yes (Where?) _____

Insurance _____ Policy # _____ Group # _____

Policy Holder Name _____ SS # _____ - _____ - _____ Relationship _____

Policy Holder's Date of Birth ____/____/____ Employer of Policy Holder _____ Work # _____

SECONDARY INSURANCE INFORMATION

Insurance _____ Policy # _____ Group # _____

Policy Holder Name _____ SS # _____ - _____ - _____ Relationship _____

Policy Holder's Date of Birth ____/____/____ Employer of Policy Holder _____ Work # _____

Do you have a Tertiary Insurance? Yes No If yes, Insurance _____

RESPONSIBLE PARTY INFORMATION

Name _____

Address _____ City _____ State _____ Zip _____

Work # _____ SS # _____ - _____ - _____ Date of Birth ____/____/____ Relationship _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize my private insurance company, Medicare, Medicaid, or any Medigap policy to pay benefits on my behalf directly to Georgia Dermatology & Skin Cancer Center, LLC, Georgia Derasurgery Centers, Inc, and or its affiliated companies. I authorize these companies to provide to my private insurance company, the Centers for Medicare and Medicaid Services, its agents or my Medigap insurer any information necessary including my signature to process claims for services rendered to my dependent. I understand I am financially responsible for all charges not covered by my insurance assignment.

Signature

Date

AUTHORIZATION FOR TREATMENT OF A MINOR

Parents often find it difficult to accompany their minor children to routine follow up appointments. This authorization has been created to give you the opportunity to authorize treatment when you are not accompanying your minor children. I authorize Georgia Dermatology, LLC to render treatment to my minor child _____ without my presence in the office.

Rev 8/29/2006 © 2006 GDSCC

Signature

Date

Return THIS FORM, YOUR INSURANCE CARD & PICTURE ID to the Receptionist