

## PATIENT REGISTRATION

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex: Male  Female  Employer \_\_\_\_\_ Retired \_\_\_\_\_ Student \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ SS # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marital Status: Single  Married  Other

Race \_\_\_\_\_ Referring Doctor \_\_\_\_\_ How did you hear about our 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 \_\_\_\_\_

### AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize my insurance company, Medicare, Medicaid, or any Medigap policy to pay benefits on my behalf directly to Georgia Dermatology & Skin Cancer Center, LLC, Georgia Dermatology Centers, Inc, and or its affiliated companies. I authorize these companies to provide to my 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 me. I understand I am financially responsible for all charges not covered by my insurance assignment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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