

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 Dermasurgery 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