Dermatology & Skin Cancer Center of Georgia, PC
Hinesville

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 Dermasurgery 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 Dermatology & Skin Cancer Center of Georgia, PC to render treatment to my minor child without my presence in the office.

__________ __________
Signature Date

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