

### 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 Dermal Surgery 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 of Tifton, LLC to render treatment to my minor child without my presence in the office.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date