# REGISTRATION FORM

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| (Please Print) |
| PATIENT INFORMATION |
| Patient’s last name: | First: | Middle Initial: | ❑ Mr.❑ Mrs. | ❑ Miss❑ Ms. | Prefers to be called: |
|  |  |
| Is this your legal name? | If not, what is your legal name? | If under 18, guardian’s name: | Birth date: | Age: | Sex: ❑ F |
| ❑ Yes | ❑ No |  |  |  / / |  | ❑ M | other\_\_\_\_ |
| We send text reminders for appointments. Please share cell phone #: | We also send email communications. Please share email: |  |
| Street address: |  | Preferred phone: |
|  |  | ( ) |
| P.O. Box: | City: | State: | ZIP Code: |
|  |  |  |  |
| Occupation: | Employer: | Employer phone: |
|  |  | ( ) |
| Other family members seen here: |  |
|  |
| IN CASE OF EMERGENCY |
| Name of local friend or relative: | Relationship to patient: | Home phone:( ) | Work phone:( ) |
|  |  |  |  |

Do we have permission to leave a message regarding your care at the preferred phone number above?

O Yes O No

Do we have permission to leave a message regarding your care on your voicemail at work?

O Yes O No

Is there anyone you approve for us to discuss your medical care with? If so, please list name(s), for example: spouses, parents, children, caregivers, living facilities. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_initials**

I have read Twin Ports Dermatology’s Notice of Privacy Practices. I know that I can ask for a copy at any time.

**\_\_\_\_\_\_\_initials**

I have read Twin Ports Dermatology’s Patient Financial Policy. We do require a 24-hour notice for cancellations please. Failure to do so will result in a $50 fee.

**\_\_\_\_\_\_\_initials**

I have read Twin Ports Dermatology’s HIPAA Acknowledgement Form

**\_\_\_\_\_\_\_initials**

**Assignment of Benefits and Related Release of Information:** I request payment of authorized benefits directly to the provider for services furnished to me at this facility or any other facility owned or utilized by Twin Ports Dermatology. I consent to the release of medical and other information related to such services for healthcare operations; and to Medicare, my insurance company, other third party payers, in order to process and pay claims, determine benefits and perform quality of care reviews. In the event that my health plan determines a service to be “not covered”, I will be responsible for those charges in full.

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| The above information is true to the best of my knowledge. |
|  | ***Patient/Guardian signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |  | ***Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |

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**MEDICAL HISTORY**

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