Minor Patient Registration Form

Child's Name: ________________________________ Date of Birth: ________________________
Last Name, First Name, Middle Initial Month/Day/Year
Sex: ___________

Who Referred You?____
*****If Physician, please list office phone number or address.*****

Patient's Social Security Number: ________________________________

Home Address: ____
Street Number Street Name Apt #

____
City State Zip Code

Patient's Home Phone:____
Area Code/Phone

Legal Guardian or Parent Name: ____

Legal Guardian or Parent's Cell Phone Number:____
Area Code/Phone Number
Legal Guardian or Parent's Work Phone Number:____
Area Code/Phone Number
Legal Guardian or Parent's E-Mail Address:____

Billing Address If Different From Above:

____
Guarantor Name

____
Street Number Street Name Apt.#

____
City State Zip Code

Primary Insurance:
*****Required***Name of Policy Holder**: ____
Last Name, First Name, Middle Initial
*****Required***Policy Holder's Date of Birth**: ___________________________________
Month/Day/Year
*****Required*** Policy Holder's Social Security Number**:________________________
*****Required***Policy Holder's Home Phone**:___________________________________
Area Code/Phone
Policy Holder's Sex: ____________

Patient relationship to policy holder: Self Child Other: _____________________

(Continued on back of page)

Secondary Insurance:

*****Required***Name of Policy Holder**: ____

Last Name, First Name, Middle Initial

*****Required***Policy Holder's Date of Birth**: ___________________________________

Month/Day/Year

*****Required*** Policy Holder's Social Security Number**:________________________

*****Required***Policy Holder's Home Phone**:___________________________________

Area Code/Phone

Policy Holder's Sex: ____________

Patient relationship to policy holder: Self Child Other: ____________________

In case of emergency please contact: ____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office**. I UNDERSTAND THAT I AM FINACIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE A COVERED BENEFIT WITH MY HEALTHECARE PLAN. THE MEDICAL SERVICES WHICH I RECEIVE TODAY WILL BE SUBMITTED TO MY INSURANCE COMPANY BASED ON THE INFORMATION I HAVE PROVIDED. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR COPAY AND OR DEDUCTIBLES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE. IF PAYMENT HAS NOT BEEN RECEIVED WITHIN 60 DAYS FROM THE DATE OF SERVICE, OR DUE TO INCORRECT INSURANCE INFORMATION, THE CHARGES BECOME MY RESPONSIBILITY AND WILL BE DUE IN FULL AT THAT TIME. OUTSTANDING OR UNPAID PATIENT PORTION BLANACES GREATER THAN 90 DAYS WILL BE SENT TO COLLECTION.** Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Franklin Dermatology and Surgery Center to release such medical information necessary for treatment, payment and health care operations (TPO) and request payment be sent directly to Franklin Dermatology and Surgery Center for my dependent. Also your signature authorizes Franklin Dermatology and Surgery Center to provide medical treatment for the minor child today and for future visits.

IT IS THE POLICY OF THIS OFFICE THAT THE ADULT PRESENTING THE CHILD FOR TREATMENT IS RESPONSIBLE FOR PAYMENT OF THE PATIENT PORTION AT THE TIME OF SERVICE.

____ ________________________

Signature of parent or legal guardian Date

Please present insurance cards and photo ID to the receptionist so cards can be scanned into the computer.