Patient Registration Form

Patient's Name:_____
Last Name, First Name, Middle Initial

Patient's Social Security Number:_____

Home Address: _____
Street Number Street Name Apt #

_____
City State Zip Code

Date of Birth: _____ Sex:_____ Marital Status: _____
Month/Day/Year Single/Married/Widowed/Divorced

Preferred Method of Contact: _____
Home Phone / Cell Phone / Work Phone

Home Phone:_____ Cell Phone: _____ Work Phone: _____
Area Code/Phone Number Area Code/Phone Number Area Code/Phone Number

E-Mail Address:_____

Employer:_____

Address: _____
Street Name, City, State, Zip Code Phone

Primary Insurance:

*****Required***Name of Policy Holder**: _____
Last Name, First Name, Middle Initial

*****Required***Policy Holder's Date of Birth:** _____
Month/Day/Year

*****Required***Patient Relationship to Policy Holder**: _____
Self/Spouse/Other

Secondary Insurance:

*****Required***Name of Policy Holder:**_____
Last Name, First Name, Middle Initial

*****Required***Policy Holder's Date of Birth**:_____
Month/Day/Year

*****Required***Patient Relationship to Policy Holder:** _____
Self/Spouse/Other

Were you referred to our office, if so please tell us who referred you?

_____

*****If Physician, please list office phone number or address. *****

In case of emergency please contact:_____
Name and phone number of family member or friend not living in your household

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 HEALTHCARE 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 BALANCES GREATER THAN 90 DAYS WILL BE SENT TO COLLECTION.** Your signature below indicates that you understand and accept this policy. Further, your signature authorizes 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 Myself/Spouse/Dependent. Also your signature authorizes Franklin Dermatology and Surgery Center to provide medical treatment today and for future visits.

_____ _____
Authorized Signature Date

Please present insurance cards and photo ID to the receptionist so cards can be scanned into the computer
(If you have Medicare please fill out back page also)

Medicare Patient One Time Authorization Agreement

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by this provider. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits for related services.

X Payment to Provider

_____ _____

Patient Signature Date

_____ _____

Provider Signature Date

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