Advanced Dermatology Center, P.C.

PATIENT REGISTRATION

Patient Name	Male/Female	SS
Street Address	Date of Birth	Marital Status **S M W SEP**
City	State	Zip
Home Phone	Cell Phone	**PCP**
E-Mail (***for patient portal purposes only***):		

PATIENT EMPLOYER INFORMATION

Employer Name	Telephone	
Employer Street Address	City/State	Zip
Patient Occupation		

POLICY HOLDERS INFORMATION

Name	Subscribers DOB / /	Tel#
Street address	City/State	Zip
Relationship to patient	Employer name	

INSURANCE

PLEASE ALLOW THE RECEPTIONIST TO MAKE A COPY OF YOUR INSURANCE CARD(S)

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

1. I authorize release of any medical information to my PCP/referring physician; to consultations if needed insurance claims and prescriptions. I also authorize payment of medical benefits to the Advanced Dermatology Center, P.C. or the party that accepts assignment. Payment is required for all services at the time they are rendered, including any applicable co-payments and deductibles.
2. I understand per federal regulations, if I have not had an office visit within 3 years, I will be considered a new patient for billing purposes and will need to be re-established. I understand I will be responsible for any services rendered at that visit.
3. I understand and agree that, regardless of any insurance status, I am ultimately responsible for the balance on any account for any professional services rendered or appointments missed. Should it be necessary to institute collection proceedings, I will be responsible for payment of finance charges and any legal fees incurred.
4. I hereby grant the clinical practitioner permission to perform such examination(s) as may be deemed necessary advisable in the diagnosis and treatment of this patient.
5. I acknowledge receipt of The Advanced Dermatology Center, P.C.'s Notice of Privacy Practices for Protected Information.
6. I have read all the information on this sheet and have completed the above answers. I certify this information and correct to the best of my knowledge. I will notify you of any changes in the above information, in my health or if my health condition changes

Patient or Responsible Party Signature: Date: