Premier Dermatology
MEDICAL • SURGICAL • COSMETIC

PATIENT REGISTRATION FORM

NAME: DATE OF BIRTH: TODAY'S DATE:

ADDRESS: CITY/STATE: ZIP CODE:

GENDER: □ MALE □ FEMALE EMAIL ADDRESS:

IF UNDER THE AGE OF 18, NAME OF PARENT/GUARDIAN:

PHONE: HOME ( ) CELL ( ) WORK ( )

PREFERRED METHOD OF CONTACT: □ HOME □ CELL □ WORK

EMPLOYER: ADDRESS:

SPOUSE'S NAME: SPOUSE'S DATE OF BIRTH:

EMERGENCY CONTACT/NOT SPOUSE: PHONE: ( ) RELATIONSHIP:

HOW DID YOU HEAR ABOUT OUR PRACTICE? REFERRED BY:

RACE/ETHNICITY: □ AMERICAN INDIAN OR ALASKA NATIVE □ASIAN □BLACK OR AFRICAN AMERICAN
□HISPANIC □ NATIVE HAWAIIAN OR PACIFIC ISLANDER □ WHITE □OTHER □ DECLINE

LANGUANGE: □ENGLISH □ SPANISH □ OTHER, PLEASE SPECIFY:

METHOD OF PAYMENT: □ INSURANCE □ SELF-PAY (LEAVE REMAINING FORM BLANK)

BILLING NAME, IF OTHER THAN PATIENT: RELATIONSHIP:

BILLING ADDRESS: PHONE:

PAYMENT REQUIRED AT TIME OF SERVICES/UNLESS PRIOR ARRANGEMENTS ARE MADE

1) PRIMARY INSURANCE:

POLICY HOLDER NAME: RELATIONSHIP TO PATIENT: POLICY HOLDER'S DATE OF BIRTH:

I.D.# GROUP#

2) SECONDARY INSURANCE:

POLICY HOLDER NAME: RELATIONSHIP TO PATIENT: POLICY HOLDER'S DATE OF BIRTH:

I.D.# GROUP#

OTHER COVERAGE:

$25 Charge for all returned checks
Cancellations with less than 24 hours notice will result in a $35 appointment fee
Cancellations with less than 48 hours notice for Procedure Appointments will result in a $35 appointment fee

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to PREMIER DERMATOLOGY/DR. ADIL USMAN for services rendered by him in person or under his supervision. I understand that I am financially responsible for any non-covered (cosmetic) services or balance not covered by my insurance. I am responsible for obtaining a referral or pre-certification for the office visit or a procedure if my insurance company/HMO/POS requires one. I will be charged full payment if I DO NOT COMPLY. I certify that the information given by me in applying for payment is correct and I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be as valid as the original.

PATIENT NAME (PLEASE PRINT): _____ **DATE:** _____
PATIENT SIGNATURE: _____
PARENT/GUARDIAN NAME (PLEASE PRINT): _____ **DATE:** _____
PARENT/GUARDIAN SIGNATURE: _____