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		
LANGUAGE: ☐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: ______________________