Premier Dermatology
MEDICAL • SURGICAL • COSMETIC

PATIENT REGISTRATION FORM

PATIENT'S NAME:	**DATE OF BIRTH:**	**TODAY'S DATE:**
ADDRESS:	**CITY/STATE:**	**ZIP CODE:**
SEX: ☐MALE ☐FEMALE ☐ OTHER	**EMAIL ADDRESS:**	
IF UNDER THE AGE OF 18, NAME OF PARENT/GUARDIAN:		
PHONE: HOME ( )	**CELL ( )**	**WORK ( )**
PREFERRED METHOD OF CONTACT: ☐ HOME	**☐ CELL**	**☐ WORK**
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:_____		
PREFERRED PHARMACY/CITY:		**PHARMACY PHONE ( )**
EMPLOYER:	**ADDRESS:**	
SPOUSE/PARTNER'S NAME:		**SPOUSE/PARTNER'S DATE OF BIRTH:**
EMERGENCY CONTACT (IF NOT SPOUSE):	**PHONE ( )**	**RELATIONSHIP:**
HOW DID YOU HEAR ABOUT OUR PRACTICE?		**REFERRED BY:**
METHOD OF PAYMENT: ☐ INSURANCE	**☐ SELF-PAY (SKIP TO ASSIGNMENT OF INSURANCE BENEFITS)**	
PERSON RESPONSIBLE FOR PAYMENT:		**RELATIONSHIP:**
BILLING ADDRESS:		**PHONE ( )**
PAYMENT REQUIRED AT TIME OF SERVICES/UNLESS PRIOR ARRANGEMENTS ARE MADE		
1) PRIMARY INSURANCE:		
POLICY HOLDER'S NAME:	**RELATIONSHIP TO PATIENT:**	**POLICY HOLDER'S DATE OF BIRTH:**
I.D.#	**GROUP#**	
2) SECONDARY INSURANCE:		
POLICY HOLDER'S NAME:	**RELATIONSHIP TO PATIENT:**	**POLICY HOLDER'S DATE OF BIRTH:**
I.D.#	**GROUP#**	
OTHER COVERAGE:		

$35 Charge for all returned checks
Cancellations with less than 24 hours' notice and no-show will result in a $50 appointment fee
Cancellations with less than 24 hours' notice and no-show for Procedure Appointments will result in a $150 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: _____