South Hills Dermatology, P.C.

PLEASE PRINT ALL INFORMATION CLEARLY

PATIENT REGISTRATION

NAME _____ SOCIAL SECURITY #_____ BIRTH DATE_____
STREET_____ CITY/STATE_____ ZIP_____
PRIMARY PHONE#_____ OTHER PHONE#_____
MARITAL STATUS_____MALE/FEMALE_____ SPOUSE NAME_____
EMERGENCY CONTACT_____ PRIMARY #_____ OTHER#_____
EMAIL ADDRESS:_____ PCP: _____ Phone#_____
HOW DID YOU LEARN ABOUT OUR OFFICE?_____

PATIENT EMPLOYER INFORMATION

EMPLOYER NAME_____ PHONE #_____
OCCUPATION/TYPE OF WORK_____

INSURANCE INFORMATION

PRIMARY INSURANCE_____ ID#_____ Group#_____
Subscriber Name_____ Relationship to Patient_____
Subscriber Date of Birth_____
SECONDARY INSURANCE_____ID#_____Group#_____
Subscriber Name_____ Relationship to Patient_____
Subscriber Date of Birth_____

RESPONSIBLE PARTY (GUARANTOR) IF PATIENT IS A MINOR

Name_____ Social Security Number _____
Street_____City/State_____Zip_____
Birth Date_____ Relationship to Patient_____
Phone#_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process insurance claims on my behalf. I permit a copy of this authorization in the place of the original.
If South Hills Dermatology does participate with my insurance company, I hereby authorize them to apply for payment of benefits on my behalf for covered services rendered by their order. I request payment from my insurance company to be made directly to the doctor.
I agree to be responsible for my bill, in full (unless other arrangements are made), within 90 days after receiving my first statement.
If South Hills Dermatology does not participate with my insurance company, I understand that I am solely responsible for all charges incurred by me, and full payment will be paid by me at the time of service.
I certify that the information I have provided on this form is true and correct to the best of my knowledge.
My signature below indicates I have read and understand the above information.

SIGNATURE:_____
DATE:_____