

**DERMATOLOGY CONSULTANTS MIDWEST, P.A.
PATIENT REGISTRATION FORM**

Patient's Name: _____ **Marital Status:** _____
First M.I. Last S M WD DIV

Patient's Address: _____
Street City State Zip

Home Phone #: _____ **Work Phone #:** _____ **Cell. Phn#** _____

Patient's SSN: _____ **Sex: M F** **Date of Birth:** _____

Employer: _____ **Occupation:** _____

Responsible Party: _____
(Parent/Legal Guardian) First M.I. Last

Responsible Party Address: _____
Street City State Zip

In the case of a minor, responsible party daytime phone #: _____

Referring physician: _____

<p>Primary Insurance: _____ (the receptionist will need to obtain a copy of your insurance card)</p> <p>Insurance ID#: _____ Group#: _____</p> <p>Subscriber Name: _____ First M.I. Last</p> <p>*Subscriber Date of Birth: _____ *Subscriber SSN#: _____</p> <p>*Subscriber Employer: _____ (*required for an insurance claim to be filed)</p> <p>-----</p> <p>Secondary Insurance: _____ (the receptionist will need to obtain a copy of your insurance card)</p> <p>Insurance ID#: _____ Group#: _____</p> <p>Subscriber Name: _____ First M.I. Last</p> <p>*Subscriber Date of Birth: _____ *Subscriber SSN#: _____</p> <p>*Subscriber Employer: _____ (*required for an insurance claim to be filed)</p>
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Payment is expected at the time of service. If the doctor you are seeing participates with your insurance plan, you will be responsible for any co-payments, co-insurance or deductibles at the time of your visit and the office will submit the claim for you. If you are a member of an HMO that requires a referral to see a specialist, you cannot be seen and receive full benefits without a current referral authorizing treatment. Please be aware that insurance coverage is a contract between you and the insurance company. Our office will do our best to get every claim paid according to your benefits but financial responsibility for the bill ultimately lies with you.

Insurance Authorization and Assignment

I request that payment of authorized Medicare/Other Insurance company benefits be made to me or on my behalf to Dermatology Consultants Midwest, P.A. for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignments apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/Other insurance company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.

Signature: _____ **Date:** _____

Patient Account Number: _____ (office use only)