central DERMATOLOGY

Registration

Patient	E-Mail		
Last	First	Middle	Social Security #
Address			Birthdate
City	State	Zip	☐ Male ☐ Female
Home Phone	Student? ☐ Yes ☐ No	Full-Time? ☐ Yes ☐ No	Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Divorced ☐ Separated
Employer	Occupation		Work Phone

Guarantor (Person Responsible for Payment) or Spouse			
Last	First	Middle	Social Security #
Address (Only if different than patient)			Birthdate
City, State Zip	Phone		Relationship to Patient

Guarantor's Employer	
Name	Occupation
Address	How Long Employed?
City, State Zip	Phone

Primary Insurance Carrier			Insured's Birthdate
Company Name			Insurance Plan or Program Name
Insured's Last Name	First	Middle	Group Number
Address			Insured's I.D. Number
City	State	Zip	Policy Number

Secondary Insurance Carrier			Insured's Birthdate
Company Name			Insurance Plan or Program Name
Insured's Last Name	First	Middle	Group Number
Address			Insured's I.D. Number
City	State	Zip	Policy Number

I understand that I am responsible for all fees, regardless of insurance coverage and that insurance eligibility does not guarantee payment. I request that payment of insurance benefits be made either to the physicians of Central Dermatology or to myself for services rendered and authorize release of medical information to the insurance carrier for billing purposes. Lastly, I realize that it is customary to pay for services when rendered unless other arrangements have been made in advance with the manager

Signature _____ Date _____