DERMATOLOGY and SKIN CANCER CENTER

Patient Registration Form

Please complete this form clearly and completely

Name: ______________________________ **DOB:** ______________________

SS#: ______________________________ **Preferred Language:** ______________________

Gender: M F Marital Status: ____________ **Ethnicity:** ____________ **Race:** ____________

Phone (H): ________________ **Phone (C):** ________________ **Phone (O):** ________________

Home Address: ____

Email Address: ____

Employer/ School: ______________________________ **Occupation/Grade:** ________________

EMERGENCY CONTACT: Name: ______________________________ **Phone:** ________________

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Insurance Information *(please note name/dob/ss of policy holder is required if policy holder is not the patient)*

Primary Insurance: ________________________

ID#: ____________________________________

Name of Policy Holder: ____________________
(Please provide DOB and SS# if policy holder is not "Self")

Relationship of Policy Holder to Patient: __________

SS#: ____________________ **DOB:** __________

Address: ________________________________

Phone #: ________________________________

Secondary Insurance: ______________________

ID#: ____________________________________

Name of Policy Holder: ____________________
(Please provide DOB and SS# if policy holder is not "Self")

Relationship of Policy Holder to Patient: __________

SS#: ____________________ **DOB:** __________

Address: ________________________________

Phone #: ________________________________

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In exchange for professional services rendered by Jeannette Hudgens, M.D., and / or Jennifer Brinckerhoff, PA-C, I hereby assign all medical and / or surgical health care benefits to which I am entitled to Dermatology and Skin Cancer Center. This statement will remain in effect until and unless revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by the insurance carrier. Outstanding balances are due within 90 days or will be sent to an outside collection agency. I understand I will be responsible for all fees associated with collection services. I hereby authorize said assignee (Dermatology and Skin Cancer Center) to release any and all information necessary to secure payment through my insurance company.

Signature of Patient / Guardian: ______________________________________ Date: ____________

Relationship to Patient: Self Parent Guardian Other