PATIENT REGISTRATION

Name: _____
First Middle Last

Prefer to be called: _____ Title: Mr. Mrs. Ms. Miss. Dr.

Address: _____
City State Zip

Home Phone: _____ Cell Phone: _____

May we leave test results or messages on your answering machine or voice mail? Yes No
May we leave test results or messages with another person at your home? Yes No
Please list any restrictions regarding release of medical information: _____

_____ **Please initial for consent:** _____

Date of Birth: _____ Social Security Number: _____

Responsible Party: _____ Relationship: _____

Date of Birth: _____ Social Security Number: _____

Alternate Address: _____
City State Zip

Alternate Phone Number: _____
Employer Phone: _____ May we call you at work? Yes No
Please initial for consent: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____

Phone: _____

Relationship: _____

I authorize the release of any medical or other information necessary for treatment, claim processing, or payment. I am aware the charges incurred for my visits may be more than the amount allowed by my insurance carrier, and I am willing to pay the billed amount. In order to avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all service at the time they are rendered unless previous arrangements have been made. We accept payment in the form of cash, check, or credit card. A $25.00 returned check fee will be applied to your account in the event of a returned check. Your signature below signifies your understanding and willingness to comply with these policies.

PATIENT/PARENT SIGNATURE _____ DATE _____

Treatment to Minors: Sometimes parents find themselves unable to accompany their children. This section has been prepared for your convenience should you find yourself unable to accompany your child: I hereby grant Manatee Dermatology permission to treat my child when he/she arrives at the office unaccompanied for a scheduled appointment.

PARENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE _____

IT IS YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES IN ADDRESS, PHONE, ETC.