



Spencer Dermatology & SKIN SURGERY CENTER

Patient Registration Form

Name as it appears on your insurance card:

_____ Jr. Sr.
First Middle Last

Date of Birth: ____/____/____ Sex: M F
Month Day Year

Address: _____ Apt # _____
Street # Street Name

City State Zip

Day Phone: (____)____-____ Evening Phone: (____)____-____

Who referred you? _____

Insurance Information: Do you have insurance? Yes No

Primary Insurance Carrier: _____

Name of Insured (Guarantor): _____ Guarantor Date of Birth: ____/____/____

Secondary Insurance Carrier: _____

Name of Insured (Guarantor): _____ Guarantor Date of Birth: ____/____/____

May we leave personal medical information on your answering machine at home? YES NO

May we e-mail personal medical information to you? YES NO

E-mail address: _____

Do you give our office permission to discuss your medical information with family members?

YES NO If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____

Phone # (day): (____)____ Phone # (evening): (____)____

Name: _____ Relationship: _____

Phone # (day): (____)____ Phone # (evening): (____)____

Emergency Contact Information:

In case of Emergency, whom should we notify? _____

Relationship to Patient: _____

Phone: (____) _____

Please present your insurance card(s) and your photo identification to the receptionist. The receptionist will make a copy and return them to you promptly.

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER AND BANK DEBIT CARDS FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

NOTICE: I authorize Spencer Dermatology to charge my credit card for any unpaid balance left on my account after insurance company reimbursements. Payment arraignments can be made. (Reimbursements included but not limited to Co-payments, Co-insurance and deductible)

Patient Signature: _____ **Date:** ____/____/____

Social Security Number: _____

Name of policy owner if other than patient: _____

Employment Information:

Employer Name: _____

Address: _____

Street # Street Name

City State Zip

Phone: _____ Extension: _____

Drivers License Number: _____

Preferred Pharmacy information:

Name of Pharmacy: _____

Address: _____

Street # Street Name

City State Zip

Phone number: _____ Fax number: _____