

## Patient Registration Form

► Please fill out completely and bring with you to your appointment ◀

Name: \_\_\_\_\_ Title:  Mr.  Mrs.  Miss  Ms.  Dr.  
First Middle Last

E-Mail: \_\_\_\_\_

Mailing / Billing Address:

Street #	Street Name	Apt#
City	State	Zip Code

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Male  Female  
Month Day Year

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_  
Name Address Phone

If married, Spouse: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

If Student:  Full Time  Part Time

Are you a resident of a Skilled Nursing Facility?  Yes  No or Hospice?  Yes  No

In case of emergency, who should be notified? \_\_\_\_\_  
Name Phone

How did you hear about Cary Skin Center? \_\_\_\_\_

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 FOR SERVICES COVERED BY INSURANCE. INSURANCE COVERAGE WILL BE PREVERIFIED AND YOU WILL BE RESPONSIBLE FOR ANY UNMET DEDUCTIBLE, COINSURANCE AND/OR COPAYMENTS. COSMETIC PATIENTS MUST PAY IN FULL AT THE TIME OF SERVICE. WE ACCEPT CASH, PERSONAL CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes Cary Skin Center to release such medical information necessary to your primary care or referring physician, to consultants if needed, and to the insurance company(s) listed below in order to process your insurance claim (if any). You herein authorize payment of medical benefits to Cary Skin Center when an assigned claim is filed to the following insurance company(s):

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Name of policy holder other than patient: \_\_\_\_\_

Social Security # of policy holder: \_\_\_\_\_ Date of birth of policy holder: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient relationship to policy owner:  Spouse  Child  Other

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

► Please present insurance cards at check-in so copies can be made. ◀