PATIENT REGISTRATION FORM

Name:_____
Last First M.I.

SSN: _____-_____-_____ **DOB:** _____/_____/_____ **Age**: _____

Race (circle one): Asian, Native Hawaiian, Pacific Islander, Black/African American, American Indian/Alaska Native, White/Caucasian

Ethnicity: Hispanic/ Not Hispanic **Language:** _____ **Gender:** Male / Female

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone #: (_____) _____-_____ Cell Home Work *(Please Circle)* **OK to leave message?** Y N

Secondary Phone #: (_____) _____-_____ Cell Home Work *(Please Circle)* **Ok to leave message?** Y N

E-Mail Address: _____ **Add to newsletter e-mail list?** Y N

Preferred Pharmacy? _____ **City:** _____

Primary Insurance Company: _____ **ID#:** _____ **Group#:** _____
Insured Person's Name: _____ **Relationship to Insured:** _____

Secondary Insurance Company: _____ **ID#:** _____ **Group#:** _____
Insured Person's Name: _____ **Relationship to Insured:** _____

Patient's Employer: _____ **Work #:** (_____) _____-_____

Emergency Contact/Relationship: _____ **Phone #:** (_____) _____-_____

Responsible Party for Bill: _____

AUTHORIZATOIN TO FILE CLAIMS/RELEASE INFORMATION: I authorize Horizon Dermatology & Aesthetics to release any information acquired in the course of my examination/treatment to the specified insurance carriers, third party payers or those involved in the processing and collecting of my claims.
AUTHORIZATION TO OBTAIN MEDICATION RECORDS: I authorize Horizon Dermatology & Aesthetics to obtain my medication record from the pharmacy database.
AUTHORIZATION TO OBTAIN MEDICAL RECORDS: I authorize Horizon Dermatology & Aesthetics to obtain medical records from other physicians and their office in order to assist in my medical care.
AUTHORIZATION TO PAY BENEFITS TO HORIZON DERMATOLOGY & AESTHETICS: I authorize payment directly to Horizon Dermatology & Aesthetics for surgical and/or medical benefits if any, otherwise payable to time for services as described below; but no to exceed the reasonable and customary charge for those services. I am aware that my insurance is filed as a courtesy and I remain responsible for all charges associated with my treatment by Horizon Dermatology including charges for my office visits and other services rendered. I agree to pay all collection expenses, including reasonable attorney fees incurred in the collections of such charges. In the event of a lawsuit for the collection of my account, I will be responsible for the reasonable attorney fees involved.

_____ _____/_____/_____
Signature of Patient/ Parent of Minor **Date**