ADVANCED DERMATOLOGY & SKIN SURGERY, P.A.

MOHS SURGERY CENTER ● ASHEVILLE VEIN CENTER ● GENERAL DERMATOLOGY ● COSMETIC DERMATOLOGY

PATIENT REGISTRATION **(Please Print)** **Today's Date ____/____/____**

Name ____
Last First M.I.

Mailing Address ____ ____________
City State Zip Code

Home Phone________________________Cell Phone_______________________Work Phone_______________________
(Area Code) (Area Code) (Area Code)

Date of Birth ____/____/____ Age_____ Sex_____ Marital Status ______ Email_________________________________

Ethnicity-Race (circle) Caucasian African American Asian American Indian Native Alaskan Hawaiian Pacific Islander

Ethnicity (circle) Non-Hispanic/Latino OR Hispanic/Latino

Language (circle) English Spanish French German Vietnamese Italian Mandarin

PARENT OR RESPONSIBLE PARTY ***(if different from patient)***

Name ____
Last First M.I.
Address____
City State Zip Code
Home Phone _________________________Cell Phone____________________Work Phone__________________________
(Area Code) (Area Code) (Area Code)
Date of Birth____/____/____ Sex__________

INSURANCE INFORMATION ***(Please present insurance card at time of check in.)***

Primary Insurance Name _________________________
Ins. Address ____________________________________
Name of Insured _________________________________
Insured's ID#____________________________________
Insured's SSN ___________________________________
Group # ____
Insured's Date of Birth ____________________________
Employer Name __________________________________
Employer Address ________________________________
Employer Phone (_____)____________________________
Relationship of patient to the Insured _________________

Secondary Insurance Name____________________________
Ins. Address _______________________________________
Name of Insured ____________________________________
Insured's ID# _______________________________________
Insured's SSN ______________________________________
Group ____
Insured's Date of Birth ______________________________
Employer Name _____________________________________
Employer Address ___________________________________
Employer Phone (____)_______________________________
Relationship of patient to the Insured ____________________

Please see other side.

I have read and understand the financial and office policy of the practice and I agree to be bound by its terms. I hereby authorize Advanced Dermatology & Skin Surgery to collect financial information arising from my treatment. This includes, but is not limited to, hospital and laboratory services. I also understand and agree that such terms may be amended from time-to-time by the practice.

Patient **OR** responsible party signature ____Date___/___/_____

Please **print** the name of the patient____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient **OR** responsible party signature ____Date___/___/_____

In order to establish optimal relations with our patients and 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 services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected at the time of service in some instances, prior to your visit. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. Deposits may be required prior to scheduling certain procedures. Delinquent accounts will be charged an administration fee of $50. Your signature below signifies your understanding and willingness to comply with this policy.

Patient **OR** responsible party signature ____Date___/___/_____