REGISTRATION FORM

PLEASE PRINT **Account Number:** ______________

Patient's Name ______________________ (Last) (First) (Middle) Age ________

Birthdate ______________ ☐ Male ☐ Female Social Security No. ______________

Address ______________________ (Street) (Apt. #) (City) (State) (Zip)

Home Phone ______________ Cell Phone ______________

Patient's Employer ______________ Work Phone ______________

If Patient is a Minor - Responsible Party

Mother's Name ______________ Employer ______________

Address (if different from above) ______________________

Father's Name ______________ Employer ______________

Address (if different from above) ______________________

Referring Doctor ______________________

INSURANCE INFORMATION

Primary Insurance ______________________

Name of Insured ______________ Birthdate __________ Relationship __________

Group # ______________ ID/SS# ______________

Secondary Insurance ______________________

Name of Insured ______________ Birthdate __________ Relationship __________

Group # ______________ ID/SS# ______________

AUTHORIZATION FOR RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS

I hereby authorize The Nashville Dermatology & Skin Cancer Clinic, P.C. to furnish to my health insurance company all the information which said insurance company may request concerning the treatment for myself or my dependents.

I hereby assign to The Nashville Dermatology & Skin Cancer Clinic, P.C. the medical and/or surgical benefits to which I and/or my dependents are entitled under my health insurance plan. I permit a copy of this authorization to be used in place of the original.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signed ______________________

Date ______________________