PATIENT REGISTRATION FORM TODAY'S DATE

PATIENT INFORMATION

NAME_____
LAST FIRST MI

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE (____) _____

CELL PHONE (____) _____

WORK PHONE (____) _____

BIRTHDATE _____ SEX: ☐ M ☐ F

EMAIL ADDRESS _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ OTHER

EMPLOYER_____

DOES YOUR INSURANCE REQUIRE A REFERRAL LETTER?

IF YES, HAVE YOU PROVIDED THE REFERRAL? ☐ YES ☐ NO

INSURANCE INFORMATION

PLEASE GIVE THE FRONT DESK YOUR INSURANCE CARD AND CO-PAYMENT.
DEBIT & CREDIT CARDS ACCEPTED

PRIMARY INSURANCE

INSURANCE NAME_____

SUBSCRIBER NAME_____

SUBSCRIBER'S EMPLOYER_____

SUBSCRIBER'S BIRTHDATE_____SEX: ☐ M ☐ F

COPAYMENT_____

SECONDARY INSURANCE

INSURANCE NAME_____

SUBSCRIBER NAME_____

SUBSCRIBER'S EMPLOYER_____

SUBSCRIBER'S BIRTHDATE_____SEX: ☐ M ☐ F

COPAYMENT_____

PRIMARY CARE DOCTOR: _____

REFERRING DOCTOR (if applicable): _____

Preferred Language: ☐ Decline to specify ☐ English ☐ Spanish ☐ Other
Ethnic Group: ☐ Decline to specify ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Race: ☐ Decline to specify ☐ White ☐ American Indian or Alaska native ☐ Asian ☐ Black or African American ☐ Other

EMERGENCY CONTACT
IN CASE OF AN EMERGENCY, LOCAL FRIEND OR RELATIVE TO BE NOTIFIED

FULL NAME_____ PHONE: (____) _____

RELEASE OF INFORMATION:

I give permission to the following person(s) to speak with anyone from Bellevue Dermatology about my health condition, billing information, and any other relevant information. ***Expires 3 years from date of signature.***

Name: _____Phone: _____Relation to Patient: _____

I assign and authorize insurance benefits to be paid directly to Bellevue Dermatology Clinic. I also understand that I am financially responsible for any balance due. I authorize release of medical information to my insurance company. I CERTIFY THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE_____ **DATE**_____

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

WE BILL ONLY THE INSURANCE COMPANIES WITH WHOM WE HAVE CONTRACTS. WE WILL GIVE YOU A COPY OF YOUR CHARGES TO SUBMIT TO YOUR INSURANCE COMPANY IF IT IS ONE WE DO NOT BILL. IN THIS CASE, PAYMENTS ARE DUE AT THE TIME OF SERVICE. PAYMENT IS ALSO DUE AT THE TIME OF SERVICE FOR ALL COSMETIC PROCEDURES. A 1% REBILLING FEE WILL BE ADDED TO BALANCES 60 DAYS AND OLDER. A FEE OF $25 WILL BE CHARGED FOR ANY CHECKS RETURNED BY THE BANK.

IF YOUR INSURANCE PLAN REQUIRES A REFERRAL OR PRIOR AUTHORIZATION FOR TREATMENT, IT IS YOUR RESPONSIBILITY TO SEE THAT THESE REQUIREMENTS ARE MET. IF THESE REQUIREMENTS ARE NOT MET, THEN ANY CHARGES INCURRED WILL BE YOUR RESPONSIBILITY.

WITH MY SIGNATURE, I ACKNOWLEDGE THAT I HAVE READ THE ABOVE STATEMENT AND AGREE TO PAY ALL CHARGES WITHIN 60 DAYS OF RECEIPT OF STATEMENT UNLESS OTHER ARRANGEMENTS ARE MADE. I UNDERSTAND THAT THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT IS NOW IN PLACE TO PROTECT MY MEDICAL RECORDS, AND THAT THE RECEPTIONIST WILL PROVIDE ME WITH A COPY OF THE OFFICE PRIVACY POLICY UPON REQUEST. I AUTHORIZE THE RELEASE OF ANY INFORMATION REQUIRED TO PROCESS MY INSURANCE CLAIMS AND AUTHORIZE MY INSURANCE COMPANY TO MAKE PAYMENTS DIRECTLY TO MY DOCTOR'S OFFICE.

SIGNATURE: _____ **DATE:** _____