

PATIENT REGISTRATION FORM

Name: _____ Jr. Sr.
first middle last

Street Address: _____ City: _____ Zip Code: _____ Home Phone (____) _____

Social Sec. #: _____ Date of Birth: _____ Age: ____ Sex: ____ Marital Status: _____

Patient's Employer: _____ Patient's Occupation: _____

Employer's Address: _____ Employer's Phone: _____

____ Full Time? ____ Part Time? ____ Retired? ____ Student? Name of School: _____

Spouse's Name: _____ Spouse's Soc. Sec. #: _____ Spouse's Date of Birth: _____

Spouse's Employer: _____ Spouse's Occupation: _____

Employer's Address _____ Phone #: _____

Responsible Party: _____ Address: _____

Soc. Sec. #: _____ Date of Birth: _____ Relationship to Patient: _____

Employer: _____ Employer's Address: _____ Phone #: _____

Nearest Relative (not living with you): _____ Phone #: _____

#1 Insurance Co. Name: _____ Policyholder's Name / SS#: _____ Date of Birth: _____

#2 Insurance Co. Name: _____ Policyholder's Name / SS#: _____ Date of Birth: _____

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 SERVICES ARE RENDERED, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE.** It is your responsibility to pay any balance not paid by your insurance. In the event the account is turned over for collection, the collection and/or legal fees, including attorney fees, shall be your responsibility. Your signature below indicates that you understand and accept this herein and authorize payment of medical benefits to the Doctor when assigned claim is filed.

Signature: _____ Date: _____

PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST SO COPIES MAY BE MADE.

Do we have permission to leave a message on your: Answering machine?____ Place of employment?____ Fax machine?____

If yes, fax #: _____ E-mail address?____ E-mail: _____

Do we have permission to discuss your medical condition with any member of your household? _____

If yes, whom? _____ Relationship: _____

Attention: Please be advised that Garrott Dermatology uses Biloxi Regional for cultures and biopsies. If your insurance does not cover Biloxi Regional, please indicate the lab or hospital to where you would like the specimens sent: _____
All services done by any hospital or lab are billed separately and it is the patient's responsibility for payment.