

PATIENT REGISTRATION FORM



PATIENT INFORMATION

Patient's Legal Name (as it appears on Driver's License or Photo ID): First Middle Last			Patient Date of Birth (MM/DD/YYYY):		
			Social Security Number:		
Mailing Address (Street, City, State, ZIP):			Patient Gender (circle): Male Female		
			Marital Status:		
Email Address:			Occupation:		
Home Phone Number:			Employer:		
Cell Phone Number:			Employer Phone Number:		
Referred to Clinic By (Please circle): Dr. _____ Family / Friend Insurance Company Web Search Print Ad Other: _____					
Primary Care Physician (PCP) Name:			PCP Phone Number (if known):		

RESPONSIBLE PARTY INFORMATION (Spouse / Parent / Legal Guardian)

Guarantor on Account (eg, responsible parent if patient is a minor):		Guarantor Phone Number:	Guarantor Relationship to Patient:
Guarantor Date of Birth (MM/DD/YYYY):	Guarantor Mailing Address (Street, City, State, ZIP):		

INSURANCE INFORMATION

Primary Insurance Company:	Policy/ID Number:	Group Number:
Policyholder's Name:	Policyholder's Date of Birth:	Relationship to Patient:
Specialist Copay Amount: \$ _____		
Secondary Insurance Company:	Policy/ID Number:	Group Number:
Policyholder's Name:	Policyholder's Date of Birth:	Relationship to Patient:

EMERGENCY CONTACT (Please list anyone you authorize to receive protected health information)

Name:	Relationship to Patient:	Phone Number:
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LEGAL INFORMATION

Assignment of Benefits: The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Epiphany Dermatology and its related companies. I understand that I am financially responsible for any balance. I also authorize Epiphany Dermatology, its related companies, or insurance company to release medical information required to process claims.

Notice of Privacy Practices: I have read or been offered a copy of Epiphany Dermatology's Notice of Privacy Practices (NPP), which explains how my medical information will be used and disclosed. I authorize the release of my medical information necessary to provide care and bill on my behalf. I understand I am entitled to a copy of the NPP. I authorize pictures of myself and of clinical focus areas to be stored in my medical record.

Consent for Communication: I understand Epiphany Dermatology will send appointment reminders and information on services via telephone, email and/or text message based on the contact information I have provided. I understand that I will have the option to opt out of future text/email reminders.

Payment Policy: Payment is due at time of service, including copays and prior balance due. I understand I am responsible for all charges for services rendered on my behalf, or on behalf of my dependents, less any amount paid by insurance to Epiphany Dermatology and its related companies.

Legal: This form applies to Epiphany Dermatology and its related companies including Epiphany Dermatology PA, Brownwood Dermatology PLLC, Epiphany Dermatology of New Mexico LLC, Epiphany Dermatology of Oklahoma, LLC, and Academy Dermatologists Group, LLC.

SIGNATURE

Patient / Guardian Signature:	Date:
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