PATIENT REGISTRATION

Account#: **Doctor:**

Home Phone: **Work Phone #:** **Cell Phone #:**

Preferred Number (please circle): Home / Work / Cell (Providing cell number authorizes calls to that number)

Ms./Mr/Mrs./Miss Name (First, Last): **DOB:**

Gender: F / M **Marital Status**: S / M / W / D / Sep **Race/Ethnicity:** **Social Security #:**

Patient Address:

Patient Employer:

Referring Doctor (optional): **Phone #:**

Referring Doctor Address:

Emergency Contact – Name, Phone #, and Relationship:

INSURANCE SUBSCRIBER INFORMATION

Primary Insurance Co.:

Policy Holder: **DOB:**

Employer: **Relationship to Patient:**

Secondary Insurance Co.:

Policy Holder: **DOB:**

Employer: **Relationship to Patient:**

AUTHORIZATION & RELEASE OF INFORMATION

I authorize all Dermatology Associates of Morris, P.A. staff to disclose all protected health information, unless I note restrictions, to the party/parties listed below until the specified expiration date. I have the right to revoke this authorization which must be in writing.

Print Name(s)	Phone Number(s)	Relationship	Expiration Date

I verify the accuracy of the above information. I authorize the release of any necessary medical information for the purposes of treatment and health care operation to other healthcare practitioners.

I authorize the release of any medical information necessary to process any claims. If the payor accepts assignment, I authorized direct payment to the physician. Services not covered by Medicare, your Managed Care Plan, or any participating insurance plan will be billed to you. The insurance company determines which services are cosmetic and which are medically necessary.

Managed Care Patients are required to bring a referral, which is valid both by date and number of visits.

I have been given the opportunity to review Dermatology Associates of Morris, P.A. HIPAA Notice of Privacy Policy.

_______________________________ Print Name

_______________________________ Signature (patient must sign if over age 18)

Date:_______________________________

_______________________________ Relationship to patient (self, guardian, parent, P.O.A.)

As per NJ state law, you have the right to request a chaperone during your examination. Please advise the doctor if you would like a chaperone present during your exam.

PLEASE NOTE: An examination of sun exposed skin for skin cancer is recommended for adults. If you would like an examination, please inform the Doctor's Assistant.

Whether you request an examination or not, please show the doctor any spots or growths that are new or have changed in appearance (size, shape, color or texture.)