

CENTER CITY DERMATOLOGY, LLC

1500 Walnut Street, Suite 1240

Philadelphia, PA 19102

Phone: 267-687-4437 Fax: 267-687-4438

REGISTRATION FORM

(Please Print)

Today's date:						
PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what is your legal name?	(Former name):		Birth date: / /	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Street address:			Social Security no.:		Home phone no.: ()	
P.O. box:		City:		State:		ZIP Code:
Occupation:		Employer:			Employer phone no.: ()	
E-mail address:						
Race (optional)		Ethnicity (optional):			Language:	
Referred to clinic by (please check one box):				<input type="checkbox"/> Dr.	<input type="checkbox"/> Insurance Plan	<input type="checkbox"/> Hospital
<input type="checkbox"/> Family	<input type="checkbox"/> Friend	<input type="checkbox"/> Close to home/work	<input type="checkbox"/> Yellow Pages	<input type="checkbox"/> Other		
Primary Care Physician:				Phone No. ()		
Referring Physician:				Phone No. ()		
Pharmacy:				Phone No. ()		
Spouse's last name:		First:	Birth date: / /			
Social Security no:			Phone No. ()			
Employer:			Employer's Phone No. ()			

INSURANCE INFORMATION						
Please give your insurance card and photo ID to the receptionist. You must notify us if this is an accident or work related visit.						
Person responsible for bill:		Birth date: / /	Address (if different):		Home phone: ()	
Is this person a patient here? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Please indicate primary insurance:						
Subscriber's name:		Subscriber's S.S. no.:	Subscriber's Birth date: / /	Group no.:	Policy no.:	Co-Payment: \$
Patient's relationship to subscriber : <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						
Please indicate secondary insurance:						
Subscriber's name:		Subscriber's S.S. no.:	Subscriber's Birth date: / /	Group no.:	Policy no.:	Co-payment: \$
Patient's relationship to subscriber : <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other						

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ()	Work phone no.: ()
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AUTHORIZATION:

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE. ALL COPAYS ARE PAYABLE AT THE TIME OF SERVICE.

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. I HERBY AUTHORIZE CENTER CITY DERMATOLOGY, LLC TO FURNISH INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO CENTER CITY DERMATOLOGY, LLC ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

HIPAA ACKNOWLEDGEMENT:

I HAVE RECEIVED AND HAVE READ CENTER CITY DERMATOLOGY, LLC'S NOTICE OF PRIVACY PRACTICES.

IN MY ABSENCE OR FOR THE BENEFIT OF GAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE FOLLOWING PERSON TO GAIN PATIENT HEALTH INFORMATION FOR OR WITH ME:

(Please list authorized Representative(s) or mark N/A

Patient/Guardian signature

Date