ACDA
aesthetic and clinical dermatology associates

PATIENT REGISTRATION FORM

Patient Information

Last Name:_____ Suffix: _____ First Name_____ MI_____

Street:_____ City: _____ State:_____ Zip:_____

Home Phone #: (____) ____-_____. Cell Phone #: (____) ____-_____. E-Mail: _____

Sex: M F Date of Birth:_____/_____/_____ Social Security #: __ __ __ - __ __ - __ __ __ __

Marital Status: S M W D Employer:_____ Work Phone #: (____) ____-_____.

Who is your Primary/General Care Physician? _____

How did you hear about our office? ☐ Physician (Whom) _____ ☐ Family/Friend_____

☐ Insurance ☐ Yellow Pages ☐ Other _____

Person to Notify in Case of Emergency: _____

Relationship: _____ Home Phone #: (____) ____-_____. Cell Phone #:(____) ____-_____.

□ **Check here if you would like to keep a credit card on file for patient balances.**

Responsible Party (If patient is a minor, person who brought minor to the office)

Last Name:_____ Suffix: _____ First Name_____ MI_____

Street:_____ City: _____ State:_____ Zip:_____

Home Phone #: (____) ____-_____. Cell Phone #: (____) ____-_____. E-Mail: _____

Sex: M F Date of Birth:_____/_____/_____ Social Security #: __ __ __ - __ __ - __ __ __ __

Marital Status: S M W D Employer:_____ Work Phone #: (____) ____-_____.

Relationship to Patient: Self Parent Spouse Other_____

Insured Person Information (If different than patient information)

Last Name:_____ Suffix: _____ First Name_____ MI_____

Street:_____ City: _____ State:_____ Zip:_____

Home Phone #: (____) ____-_____. Cell Phone #: (____) ____-_____ E-Mail: _____

Sex: M F Date of Birth:_____/_____/_____ Social Security #: __ __ __ - __ __ - __ __ __ __

Marital Status: S M W D Employer:_____ Work Phone #: (____) ____-_____.

Relationship to Patient: Self Parent Spouse Other_____

Assignment and Release

My signature below authorizes the doctor to release my medical information necessary to process my insurance claims. I authorize payment of medical benefits to the doctor when an assigned claim is filed. I authorize that any benefits due to me be paid directly to the physician. I also understand payment is expected at the time of service (all co-pays and balances due must be paid when the service is given). By signing this form, I acknowledge that I have received ACDA's Financial Policy and am aware that it can change at any time.

_____ _____ _____

Patient Signature Parent Signature (if patient is a minor) Date