THE CAPITAL DERMATOLOGY MEDICAL GROUP
PATIENT REGISTRATION FORM
(Please Print)

Appointment Confirmation Phone # ( )				Email:		
DEMOGRAPHIC INFORMATION						
Patient's Last Name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital Status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Preferred Language:	Birth Date: / /	Age:	Sex: ❑ M ❑ F	
Street Address:		Social Security #:	Home Phone #: ( )			
Cell Phone #:	City:	State:	ZIP Code:			
Primary Care Doctor or Referring Provider:						
Preferred Pharmacy:	Pharmacy Location:					
INSURANCE INFORMATION (SUBSCRIBER OR GUARNTOR)						
(Please give your insurance card with photo ID to the receptionist.)						
Primary Insurance Holder:	Birth Date: / /	Address (if different):	Home Phone #: ( )			
Is this patient covered by insurance?	❑ Yes	❑ No				
Primary Insurance:	Subscriber's Name:					
Subscriber's Social Security #:	Birth Date: / /	Group no.:	Policy #:	Co-pay: $		
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		
Name of secondary insurance (if applicable):	Subscriber's Name:	Group #:	Policy #:			
Patient's relationship to subscriber:	❑ Self ❑ Spouse ❑ Child ❑ Other					
Race/Ethnicity (Please circle one)						

Hispanic / Mexican	Filipino	Samoan	Asian Indian	Pacific Islander
Black / African American	American Indian	Japanese	Vietnamese	Other
Caucasian	Native Hawaiian	Korean	Asian	
Puerto Rican	Cuban	Chinese	Guamanian	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home Phone #: ( )	Work Phone #: ( )

AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION: 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. ALL SERVICES PROVIDED TO YOU AS A PATIENT OF THE CAPITAL DERMATOLOGY MEDICAL GROUP ARE PAYABLE AT TIME OF SERVICE AND ARE THE SOLE RESPONSIBILITY OF YOU "THE PATIENT" AND/OR GUARANTOR OF "YOUR CHILDREN".

I HERBY AUTHORIZE THE CAPITAL DERMATOLOGY MEDICAL GROUP TO FURNISH INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENTS) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE CAPITAL DERMATOLOGY MEDICAL GROUP, PC ALL PAYMENTS FORMEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS.

I UNDERSTAND THAT I AM **RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE**.

I HEREBY AUTHORIZE AND RELEASE THE DOCTOR AND WHOMEVER HE/SHE MAY DESIGNATE AS HIS/HER ASSISTANT TO ADMINISTER TREATMENT, PHYSICAL EXAM, X-RAY STUDIOS, LABORATORY PROCEDURES, MEDICAL CARE OR ANYCLINICAL SERVICE THAT HE/SHE DEEMS NECESSARY IN MY CASE, AND I FURTHER AUTHORIZE HIM/HER TO DISCLOSE ALL OR PART OF MY (PATIENTS) RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OR TO THEPATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE CLINIC CHARGE, INCLUDING BUT NOT LIMITED TO HOSPITAL OR MEDICAL SERVICES COMPANY, INSURANCE COMPANY, WORKERS COMPENSATION CARRIERS, WELFARE FUNDS, OR THE PATIENTS EMPLOYER.

PATIENT INFORMATION CONSENT: I UNDERSTAND THAT THE CAPITAL DERMATOLOGY MEDICAL GROUP. MAY NEED TO USE AND DISCLOSE INFORMATION ABOUT MY HEALTH OR MEDICAL PROBLEMS FOR THE PURPOSE OF ARRANGING, CONDUCTING, OR REFERRING MY TREATMENT; FOR OBTAINING PAYMENT FOR SERVICES, AND FOR THE PURPOSE OF OPERATING THE PRACTICE. I CONSENT TO THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

I UNDERSTAND THAT **MY CONSENT IS NOT NEEDED IF THE LAW REQUIRES** THE CAPITAL DERMATOLOGY MEDCIAL GROUP TO REPORT SOME ASPECT OF MY PROTECTED HEALTH INFORMATION TO A GOVERNMENT AGENCY (FOR EXAMPLE, SUSPECTED ABUSE, COMMUNICABLE DISEASE AND POTENTIAL BODILY HARM TO MYSELF OR OTHERS).

I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW THE CAPITAL DERMATOLOGY MEDICAL GROUP PRIVACY NOTICE, TOREQUEST RESTRICTIONS BE PUT ON THE USE OF MY INFORMATION, AND TO REVOKE MY CONSENT AT A LATER DATE.

I UNDERSTAND THAT IF I WITHHOLD CONSENT FOR THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT OR OPERATIONS, **THE CAPITAL DERMATOLOGY MEDICAL GROUP MAY REFUSE TO UNDERTAKE MY CARE**.

I, THE UNDERSIGNED, HEREBY CONSENT TO THE FOLLOWING TREATMENT: ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS ADMINISTRATION OF ANY NEEDED ANESTHETICS, PERFORMANCE OF SUCH PROCEDURES AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE TREATMENT OF THIS PATIENT, USE OF PRESCRIBED MEDICATION, PERFORMANCE OF DIAGNOSTIC PROCEDURES/TESTS, CULTURES, BIOPSIES AND SURGERY, PERFORMANCE OF OTHER MEDICALLY ACCEPTED LABORATORY TESTS THAT MAY BE CONSIDERED MEDICALLY NECESSARY OR ADVISABLE BASED ON THE JUDGMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNEES. I FULLY UNDERSTAND THAT THIS IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT. I INTEND THIS CONSENT TO BE CONTINUING IN NATURE EVEN AFTER A SPECIFIC DIAGNOSIS HAS BEEN MADE AND TREATMENT RECOMMENDED. THE CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING. I UNDERSTAND THAT THE CAPITAL DERMATOLOGY MEDICAL GROUP MAY INCLUDE CONSENT AT SATELLITE OFFICES UNDER COMMON OWNERSHIP.

MEDICARE PATIENTS: I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINISTRATIONOR ITS INTERMEDIARIES FOR MY MEDICARE CLAIMS. I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TOTHE CAPITAL DERMATOLOGY MEDICAL GROUP

HIPPA ACKNOWLEDGEMENT: I HAVE RECEIVED AND HAVE READ THE CAPITAL DERMATOLOGY MEDICAL GROUP 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)

Do we have your permission to:

Leave a message on your answering machine or cell phone? YES or NO
Contact you via email? YES or NO
Discuss your medical conditions with any member of your household? YES or NO

CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENT. ALSO THAT ALL INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO MY KNOWLEDGE.

PATIENT (OR GUARDIAN) Signature **Date**