GARDEN CITY DERMATOLOGY & THE GARDEN SPA-PATIENT REGISTRATION

This form MUST be completed in its entirety, signed and dated. Please return completed form, insurance ID card and photo ID to the front desk.

Last name: _____Middle initial: ____ First name: _____☐M ☐F

Address: _____ Apt#:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ Cell: _____

SS#: _____-_____-_____ Date of Birth: _____/_____/_____ Email address: _____

Emergency Contact Name:_____ _____ Phone: _____ Relation: _____
Marital Status: ☐married ☐single ☐divorced ☐widow(er) Spouses name:_____
Employment: ☐employed ☐Retired ☐unemployed ☐ Student
Employer: _____ Address: _____ Phone: _____
Referred by: ☐ physician/ medical professional ☐ friend Name_____ Phone: _____

Insurance Coverage: ☐ please check if you are uninsured or will be considered as self pay. If using insurance coverage-complete the following.

Does your policy require a referral to obtain medical care from a specialist? ☐ YES ☐ NO **Primary insurance carrier**:_____ Policy#:_____ Name of Policy holder: ☐ please check if the same as patient. If not complete the following: Name:_____ DOB: _____/_____/_____ SS#: _____ Address and phone: _____ _____ Relationship to patient:_____	☐ Please check here if there is no secondary coverage otherwise please complete the following. **Secondary insurance carrier**:_____ Policy#: _____ Name of Policy holder: ☐ please check if the same as patient. If not complete the following: Name:_____ DOB: _____/_____/_____ SS#: _____ Address and phone: _____ _____ Relationship to patient:_____

I hereby authorize and direct the above named practice, having treated me to release to governmental agencies, insurance carriers, or others who are financially liable for my medical care, all information needed to substantiate payment for such medical care and permit representative therefore to examine and make copies of records relating to such treatment. Upon request for release of records, I hereby authorize Garden City Dermatology, PC to furnish all records and results to the parties I specify. I hereby assign, transfer and set over the above named practice sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical cost of care and treatment rendered to myself or my dependent in said practice. I agree to pay all monies, including the full original fee, all $20 administrative fees and 1.5% monthly interest so that Garden City Dermatology receives full reimbursement of monies due. I acknowledge that the information provided above is accurate. The following will result in you being held responsible for full payment regardless of your insurance contracts: if you provide inaccurate/incomplete insurance information, if your plan requires a referral and you do not secure one, if your plan requires that you be seen by an in network provider and our providers are not defined as such with your insurance carriers. I understand that I am responsible for any and all services not covered by my insurance company. I accept responsibility for payment of my account.

SIGNATURE: _____ DATE: _____
(If patient is UNDER 18,☐ parent or ☐ legal guardian must sign. If patient is 18 or over, patient must sign)

For office use only: form reviewed and accepted by: _____