Mary T. Pentel, M.D.

Southside Dermatology

MINOR PATIENT REGISTRATION FORM

Patient Information (please print) Date:_____

Name: _____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip Code:_____

If Student: ☐ Full time
☐ Part time Name of School:_____

Parent or Legal Guardian Information

Parent or Legal Guardian Name: _____ Date of Birth:_____

Telephone (home):_____ Social Security Number:_____

Employer:_____ Telephone (work):_____

City:_____ State:_____ Zip Code:_____

In order to establish optimal relations with our patients and avoid any misunderstanding regarding our payment policies, PAYMENT, INCLUDING CO-PAYS AND DEDUCTIBLES, IS EXPECTED AT THE TIME OF SERVICE. Your signature below indicated that you understand and accept this policy. Further, your signature authorizes Dr. Mary T. Pentel and Southside Dermatology to release such medical information necessary to process your insurance claims if applicable. You herein authorize payment of medical benefits to the physician when an assigned claim is filed. It is the policy of this office that the adult presenting the minor for treatment is responsible for payment of the patient portion at the time of service.

_____ _____
Signature of parent or legal guardian Date

Name of policy owner if other than patient:_____
Patient relationship to policy owner: ☐ Self ☐ Child ☐ Other:_____

I, _____, legal guardian of minor _____, authorize Southside Dermatology and its physician, Dr. Mary Pentel, to treat the above mentioned minor.

_____ _____
Parent or legal guardian signature Date

Please present insurance cards and a photo identification to the receptionist so copies may be made. Do we have your permission to:

Leave a message on your answering machine at home?	☐ yes	☐ no
Leave a message at your place of employment?	☐ yes	☐ no
Discuss your medical condition with any member of your household?	☐ yes	☐ no

If yes, whom:_____ Relationship:_____

_____ _____
Parent or legal guardian signature Date