FOOTHILL DERMATOLOGY
MEDICAL CENTER

Patient Registration Form

Name: ____ ☐ Jr. ☐ Sr.
First Middle Last

Prefer to be called: ______________________________ Title: ☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss

NO PO BOXES
Address: ____
Street Name Apt #

____
City State Zip

Employer: ____
Name Address Phone

Home Phone: ______________________________ Date of Birth: _____/_____/_____
Month Day Year

Work Phone: ______________________________

Social Security Number: ______________________ AGE:______ Sex: ☐ M ☐ F

If Student: Full Time Part Time Name of school:______________________

To receive special promotions and/or important updates via email.

Email Address____

Spouse: ______________________________ Who Referred You? ______________________________

Spouse's date of birth? ____/____/____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTER CARD FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when an assigned claim is filed.

______________________________ ______________________________
Signature of patient or legal guardian Date

Name of policy owner other than patient: ______________________________

Patient relation to policy owner: ˇ Self ˇ Child ˇ Other: ______________________

Should the account fall into the arrears greater than 60 days, I authorize that unpaid balance to be charged to my major credit card, as listed below. **Please present insurance cards and photo I.D to the receptionist so copies may be made.**

Do we have permission to:

Leave a message in 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______________________

______________________________ ______________________________
Patient Signature Date

Foothill Dermatology
Medical Center

RESPONSIBLE PARTY
(PATIENT OR PARENT IF UNDER THE AGE OF 18)

Today's Date____/____/______

Name____
Last First M.I.

Address____
City Apt# State Zip Code

Home Phone____________________ Work Phone___________________
Area code Area code
SS#_____________________________

Date Of Birth___/___/____ Sex ____

INSURANCE INFORMATION (Please present insurance card at time of check in)

Primary Insurance Name________________________ Secondary Insurance Name____________________

Name of Insured_______________________________ Name of Insured_____________________________

Employer Name_______________________________ Employer Name______________________________

Employer Phone______________________________ Employer Phone_____________________________
Area Code Area Code
Relationship of patient to the Insured_______________ Relationships of patient to the Insured____________

Other members that are patients ____
Pharmacy of Choice____ Phone__________________

In Case of Emergency, whom should we notify? ________________________________ Phone__________________

Primary Care Physician ____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient of Responsible Party Signature ____ Date____/____/______

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment polices, our staff is trained to consistently inform you of the financial payment policies of the office. Payment is required for all services at the time they are rendered unless you are in a repaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event that your account must be turned over to collections, a $25.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature____ Date____/____/______

Copy of insurance card (both sides) attached. Updated By