Account #	Insight Dermatology 9878 Hibert Street, Suite 100 San Diego, CA 92131 858-693-3000	
Date:	**PATIENT REGISTRATION INFORMATION**	

PATIENT INFORMATION

Name		Date of Birth	Social Security Number	
Home Address		City	State	Zip
Primary Phone Number	Secondary Phone Number		Sex □ Male □ Female	
E-Mail Address	Status: □ Single □ Married □ Other_____		Primary Physician:	
Employer	Occupation		Referring Physician	
Preferred Pharmacy Name, Location, Address, Phone If Known	How did you hear about us? **If internet or ad, please be specific.**			

RESPONSIBLE PARTY INFORMATION (Required for patients under 18 years of age)

Responsible Party Name	Responsible Party Home Phone			Responsible Party Social Security Number
Responsible Party Address	City	State	Zip	Relationship To Responsible Party □ Self □ Spouse □ Son □ Daughter
Responsible Party Employer	Occupation			Responsible Party Work Phone Number

EMERGENCY INFORMATION

Name of Emergency Contact	Relationship to Patient	Phone

COMMUNICATION OF PERSONAL HEALTH INFORMATION

Do we have permission to:

Leave a voice-mail message with your private health information at your primary phone number? □ Yes □ No
Leave a voice-mail message with your private health information at your place of employment? □ Yes □ No
Discuss your medical condition with a family member? □ Yes □ No
If yes, please give name:_____ Relationship to you:_____

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

ASSIGNMENT OF BENEFITS
I hereby authorize direct payment to Insight Dermatology, of any medical benefits payable to me for the services provided at Insight Dermatology. I also understand that it is my responsibility to obtain any required referral authorization prior to my appointment time. If I fail to obtain said referral, I will be responsible for the unpaid balance due. I am also responsible for any co-payment, deductible, or patient portion on the day of service. I understand that if my account becomes delinquent, I will be held responsible for reasonable attorney's fees, court costs, and collection costs. I am aware that I may be charged a fee of $25.00 for any appointment missed without 24 hours prior notice.

MEDICAL RECORDS RELEASE
I hereby authorize Insight Dermatology to release my records to my insurance company and/or primary care physician for the purpose of processing my insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payer.

PHOTOGRAPHIC CONSENT
For the purpose of medical evaluation, I hereby consent to pre- and post-treatment digital photographs during the course of this and subsequent visits at Insight Dermatology. I understand that these images may be identifiable and will remain a part of my medical record. I also understand that these images will not be used in advertising media without my consent, but may be used for educational and clinical research purposes.

X_____
Patient Signature or Signature of Parent or Guardian **Date**