

Insight Dermatology

9878 Hibert Street, Suite 100 San Diego, CA 92131 858-693-3000

Date:

PATIENT REGISTRATION FORM**PATIENT INFORMATION**

| | | | | |
|----------------------|--|---------------|--|-----|
| Name | | Date of Birth | Social Security Number | |
| Home Address | | City | State | Zip |
| Primary Phone Number | Secondary Phone Number | | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| E-Mail Address | Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other _____ | | Primary Physician: | |
| Employer | Occupation | | Referring Physician | |

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 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> 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 any associated costs. I am aware that I may be charged a late cancellation or no-show fee without 24 hours advanced notice for a routine visit or 48-72 hours advanced notice for a scheduled procedure.

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.

SUNSHINE ACT DISCLOSURE

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>.

X

Patient Signature or Signature of Parent or Guardian

Date