

Clear Skin Dermatology

Family Registration (Please Print)

For Office Use Only: Account # _____

Parent/Legal Guardian (if patient is under 18 years of age)

OR

Patient (if patient is 18 years of age or older)

Last Name _____ Home Phone _____

First Name _____ Sex (M/F) _____ Work Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip Code _____ Date of Birth _____

Family Doctor _____ City _____ Phone # _____ Social Security # _____

Email Address _____

Employer Information:

Employer Name _____

Employer Address _____

City _____ State _____ Zip _____

In Case of an Emergency Call:

Name _____

Phone _____

Dependent Information:

1) Dependent Name _____ Dependent Date of Birth _____

2) Dependent Name _____ Dependent Date of Birth _____

Primary Care Physician: _____ PCP Phone: _____

Primary Insurance Information: (Copays are expected at the time of visit)

Name of Insurance Policy _____ Type of Plan (PPO, HMO, EPO, POS) _____

Policy # _____ Group # _____ Copayment \$ _____

Name of Policy Holder _____ Relationship to Patient _____

Social Security # _____ Date of Birth _____

Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Employer Name _____ Employer Phone # _____

Secondary Insurance Information:

Name of Insurance Policy _____ Type of Plan (PPO, HMO, EPO, POS) _____

Policy # _____ Group # _____

Name of Policy Holder _____ Social Security # _____ Date of Birth _____

Employer Name _____ Employer Phone # _____

How did you hear about us?

Doctor: (Whom can we thank?) _____

Phone Book

Insurance company

Friend: (Whom can we thank?) _____

Physician Finder (Delnor)

Home Mailer

Newspaper Ad: (what paper?) _____

Newspaper Article

Signature: _____ Date: _____

Our office accepts: Cash Checks Visa Mastercard

Please complete back side of form → → → →

ASSIGNMENT OF BENEFITS

West Suburban Dermatology & Cosmetic Surgery / Clear Skin Dermatology

CONSENT FOR TREATMENT, RELEASE, ASSIGNMENTS AND FINANCIAL AGREEMENT:

I hereby voluntarily consent to care encompassing routine diagnostic procedures and medical treatment authorized by Dr. Jazayerli. I authorize any holder of medical or other information about me to release any information needed to process my insurance claims and to permit a copy of this authorization to be used in place of the original. I authorize payment of medical benefits to West Suburban Dermatology & Cosmetic Surgery / Clear Skin Dermatology. I also authorize, at my request release of medical records. I absolutely and unconditionally guarantee payment in full for clinical services rendered to me by West Suburban Dermatology & Cosmetic Surgery / Clear Skin Dermatology.

Signature

Date

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS, AND PATIENTS

MEDICARE PATIENTS ONLY:

I request that payments of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in West Suburban Dermatology & Cosmetic Surgery / Clear Skin Dermatology, including my physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature

Date

Printed Name

Medicare Number (HICN)

I request that payment of authorized MediGap benefits be made either to me or on my behalf to West Suburban Dermatology & Cosmetic Surgery / Clear Skin Dermatology for any services furnished to me by my physician. I authorize any holder of medical or other information about me to release to _____ (Name of Secondary) any information to determine these benefits or the benefits payable for related services.

Signature

Date

WEST SUBURBAN DERMATOLOGY & COSMETIC SURGERY

Request to Receive Confidential Communications of Protected Health Information

As stated in our Notice of Privacy Practices, you may request that we communicate confidential health information to you by alternative means or in alternative locations. The Privacy Rule requires us to accommodate requests if reasonable.

Please indicate your request regarding communication below and answer ALL the questions listed. If it does not apply, please mark the NA field.

APPOINTMENT CONFIRMATIONS

- Yes No NA Leave message on my home answering machine.(Number)_____
- Yes No NA Leave message with persons at my home.
- Yes No NA Call me on my cell phone. (Number)_____
- Yes No NA Leave message on my cell phone voice mail.

Best way to reach you regarding your appointments? _____

CONFIDENTIAL INFORMATION (including results, medical information)

- Yes No NA Contact me at my home
- Yes No NA Leave message on my home answering machine
- Yes No NA Leave message with persons at my home
- Yes No NA Call me on my cell phone
- Yes No NA Leave message on my cell phone voice mail
- Yes No NA Contact me at my work (Number)_____
 - If yes, OK to leave a message? Yes No

Best way to reach you regarding your confidential information? _____

Yes No Do you have a Medical Power of Attorney Assigned?
If YES, please provide us with a copy
 If you want a family member to have access to your personal health information, please list their name and relationship to you.

Yes No Can we send sealed confidential information to your home address
If NO, list another address

Other requests for confidential communications: _____

 Child Name (if applicable)

 Child Name (if applicable)

Patient Receipt of Notice of Privacy Practices
I have received the Notice of Privacy Practices from my physician

 Patient (if >18years old) or Parent **Signature**

 Date