ACCOUNT:	**DERMATOLOGY INSTITUTE** 256 Landis avenue, Third floor Chula Vista, CA 91910	
DATE:	# PATIENT REGISTRATION INFORMATION	

PATIENT INFORMATION

NAME:	DATE OF BIRTH:	SOCIAL SECURITY NUMBER:		
HOME ADDRESS:	CITY:	STATE:	ZIP:	GENDER:
HOME PHONE NUMBER:	CELL PHONE:	WORK PHONE:		
DRIVER'S LICENSE:	E-MAIL ADDRESS:	MARITAL STATUS:	REFERRING PHYSICIAN:	
EMPLOYER:	OCCUPATION:	PRIMARY PHYSICIAN:		
PREFERRED PHARMACY NAME, LOCATION, ADDRESS, PHONE IF KNOWN:	HOW DID YOU HEAR ABOUT US?	PREFERRED LANGUAGE:		

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

RESPONSIBLE PARTY NAME:	RESPONSIBLIE PARTY HOME PHONE:			RESPONSIBLE PARTY SOCIAL SECURTY NUMBER:
RESPONSIBLE PARTY ADDRESS:	CITY:	STATE:	ZIP:	RELATIONSHIP TO RESPONSIBLE PARTY:
RESPONSIBLE PARTY EMPLOYER:	OCCUPATION:	RESPONSIBLE PARTY WORK PHONE NUMBER:		

EMERGENCY INFORMATION

NAME OF EMERGENCY CONTACT NOT LIVING WITH YOU:			RELATIONSHIP TO PATIENT:	
ADDRESS:	CITY:	STATE:	ZIP:	PHONE:

INSURANCE INFROMATION

PRIMARY INSURANCE:	SSN:	SUBSCRIBER NAME:	DATE OF BIRTH:
GROUP NUMBER:	IDENTIFICATION NUMBER:		
SECONDARY INSURANCE:	SSN:	SUBSCRIBER NAME:	DATE OF BIRTH:
GROUP NUMBER:	IDENTIFICATION NUMBER:		

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE:

- ASSIGMENT OF BENEFITS

I hereby authorize direct payment to dermatology institute, of any medical benefits payable to me for the services provided at dermatology institute. 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 charged a fee of $35.00 for any appointment missed without 24 hours prior notice.

- MEDICAL RECORDS RELEASE

I hereby authorize dermatology institute 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 dermatology institute. 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_____ Date: _____

Patient signature or signature of guardian or parent.