

Park Avenue Dermatology Patient Registration Form

New Patient Name Change Address Change Insurance Change

IMPORTANT: Please present ALL Insurance cards to the receptionist. If patient is a minor and you are not the legal guardian, speak with the receptionist immediately

Patient Information: Please Complete All Fields Using Legal Names of the Parties Involved.

Name: First _____ MI _____ Last _____
Date of Birth: _____ Age: _____ Occupation: _____ Sex: Male Female
Social Security #: _____

Mailing Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____
Cell Phone: _____ Work: _____ Home: _____
E-mail: _____

Marital Status (Please Circle): Single Married Separated Divorced Widowed

Pharmacy Name: _____ Address/Town/Phone #: _____

Referring Physician or Primary Doctor Name: _____
Address/Town: _____ Phone #: _____

How did you hear about us (Please Circle): Internet/Website | Advertising | Ins.Co. | Friend/Relative (Name _____)

Insurance Information:

PATIENT IS RESPONSIBLE FOR INFORMING OUR OFFICE OF PARTICIPATING LAB: _____

Primary Insurance Carrier Name: _____

Name: First _____ MI _____ Last _____
Date of Birth: _____ SS#: _____ - _____ - _____ Relationship to the Patient: _____
Mailing Address: _____
Cell Phone: _____ Home: _____ Work: _____

Secondary Insurance Carrier Name: _____

Annual Deductible: \$ _____ Co-pay: \$ _____

Does this insurance require a referral? Yes _____ No _____ (Patient is responsible for referrals at the time of the visit)

EMERGENCY Contact Person:

Name _____ Phone #: _____

Patient Release: Must be signed by patient if over 18 or by legal guardian of patient under 18.

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process Insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.

I certify that I hereby authorize Ligresti Dermatology Associates, its providers and staff to provide my minor child in my absence with examinations and basic treatments for which additional consents are not required. I understand as the legal guardian of this child I am required to be physically present to consult with the provider on any procedures which required separate consent such as surgery, biopsy, or wart destructions. I understand additional written consent maybe necessary for these types of procedures and the legal guardian must be present for such consent.

Signature: _____ Date: _____

Would you like a complementary COSMETIC CONSULTATION during your visit today? Yes No