Dermatology Associates of Coastal Carolina
701 Doctors Drive, Suite F
Kinston, NC 28501 Ph. (252) 686-0991

PATIENT REGISTRATION FORM

CHART #:_____

PATIENT NAME: _____ **DATE OF BIRTH:** _____ **SEX:** M F
First Mi. Last

ADDRESS: _____

E-Mail Address _____

HOME PHONE #: (_____)____-_____**WORK PHONE #:** (_____)____-_____ **CELL PHONE:** (_____)____-_____

PRIMARY CARE PHYSICIAN: _____ **REFERRED BY:** _____

PHARMACY _____ **PHARMACY PHONE #** _____

DO WE HAVE YOUR PERMISSION TO:

Leave a message on your home answering machine/voice mail? **YES** **NO**

Leave a message at your place of employment? **YES** **NO**

Person(s) authorized to receive any of your medical and/or financial information:

NAME RELATIONSHIP PHONE NUMBER

_____

_____

_____

If you do not wish for certain unauthorized persons to receive all information, specify to the side what he or she may not receive:

INSURANCE INFORMATION (Please present insurance card(s) at time of check in.) ****PLEASE NOTE****
As a courtesy we glad to file insurance for you. However, in order to do so the following information needs to be provided in its entirety. Any balance remaining after you insurance has been processed will become your responsibility. Any incomplete information will result in us not being able to file your insurance claims and you will be given the options either pay in full for services rendered on the day of your visit or to reschedule your appointment

Patient or Guardians Signature _____ **Date**: _____/_____/_____

PATIENT NAME: _____ **CHART #:_____**

PRIMARY INSURANCE
(The insurance that is filed first.)

INSURANCE NAME: _____

SUBSCRIBER'S NAME: _____
(Policy holder. Person to which the insurance is issued.)

SUBSCRIBER'S DATE OF BIRTH: ____/____/_____

SUBSCRIBER'S ID#: _____

GROUP#: _____

RELATIONSHIP OF PATIENT TO SUBSCRIBER:

_____

SECONDARY INSURANCE
(Your supplement insurance/the insurance we file after primary.)

INSURANCE NAME: _____

SUBSCRIBER'S NAME: _____
(Policy holder. Person to which the insurance is issued.)

SUBSCRIBER'S DATE OF BIRTH: ____/____/

SUBSCRIBER'S ID#: _____

GROUP#: _____

RELATIONSHIP OF PATIENT TO SUBSCRIBER:

_____

I hereby assign, and set over **DERMATOLOGY ASSOCIATES OF COASTAL CAROLINA** all of my rights and interest to my medical reimbursement benefits under my Medicare or any other government agency or private insurance policy. I authorize **DERMATOLOGY ASSOCIATES OF COASTAL CAROLINA** to perform any services necessary for proper treatment. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by my insurance (including deductibles, co-insurance and non-covered medical procedures). HIPAA: I hereby give my consent for **DERMATOLOGY ASSOCIATES OF COASTAL CAROLINA** to use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and healthcare operations. I have received and read the NOTICE OF PRIVACY PRACTICES prior to signing this consent.

_____ _____

Patient or Guardian's Signature **Date**