CHILD PATIENT REGISTRATION

DATE ______/______/__________

LAST NAME ____________________ FIRST NAME ____________________ INITIAL ______

ADDRESS STREET ____

CITY ____________________ STATE ______ ZIP __________

HOME PHONE (______) ____________________

FATHER'S NAME ____________________ WORK # ____________________

MOTHER'S NAME ____________________ WORK # ____________________

PERSON RESPONSIBLE FOR BILL: (CIRCLE)

PARENT GUARDIAN OTHER __________

LAST NAME ____________________ FIRST NAME ____________________ INITIAL ______

ADRESS (IF DIFFERENT FROM PATIENT)

STREET ____

CITY ____________________ STATE ______ ZIP __________

PATIENT'S DATE OF BIRTH ______/______/______ CIRCLE SEX: MALE FEMALE

PATIENT'S SOCIAL SECURITY # (IF KNOWN) ____________________

REFERRING PHYSICIAN ____

ADDRESS ____

____

I AUTHORIZE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS ANY INSURANCE CLAIMS AND I AUTHORIZE PAYMENT OF MEDICAL BENEFITS DIRECTLY TO BERNSTEIN & ROBINSON DERMATOLOGY, P.A. I UNDERSTAND I AM RESPONSIBLE FOR ANY DEDUCTIBLES, CO-INSURANCE/OR AMOUNTS FOR SERVICES NOT COVERED BY THE INSURANCE CARRIER. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL.

DATE ____________________ SIGNATURE ____________________

PLEASE TURN OVER AND FILL OUT OTHER SIDE

DATE ______ / ______ / ______ PATIENT'S NAME ____________________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY ____________________

ADDRESS STREET ____________________

CITY ____________________ STATE ______ ZIP ______

COMPANY PHONE # (______) ____________________

MEMBERSHIP # ____________________ FEP # ____________________

DEDUCTIBLE $ ____________________ CO-PAY $ ____________________

GROUP NAME
OR COMPANY CARRYING POLICY ____________________

GROUP NUMBER ____________________

PRIMARY INSURANCE IN NAME OF ____________________

GUARANTOR'S SOCIAL SECURITY NUMBER ____________________

CIRCLE SEX: MALE FEMALE DATE OF BIRTH ______ / ______ / ______

CIRCLE PATIENT'S RELATION TO HOLDER: SPOUSE SELF CHILD
OTHER ____________________

SECONDARY INSURANCE COMPANY ____________________
(IF ANY)

ADDRESS STREET ____________________

CITY ____________________ STATE ______ ZIP ______

COMPANY PHONE # (______) ____________________

MEMBERSHIP # ____________________ FEP # ____________________

DEDUCTIBLE $ ____________________ CO-PAY $ ____________________

GROUP NAME
OR COMPANY CARRYING POLICY ____________________

GROUP NUMBER ____________________

SECONDARY INSURANCE IN NAME OF ____________________

CIRCLE SEX: MALE FEMALE DATE OF BIRTH ______ / ______ / ______

CIRCLE PATIENT'S RELATION TO HOLDER: SPOUSE SELF CHILD
OTHER ____________________

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DATE ____________________ SIGNATURE ____________________

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