REGISTRATION INFORMATION

PATIENT INFORMATION						**DATE:**
LAST NAME	FIRST NAME	MI	BIRTHDATE			SOCIAL SECURITY #
HOME ADDRESS	CITY		STATE	ZIP		SEX: ☐MALE ☐FEMALE
SPOUSE'S NAME	HOME #		WORK #			
EMAIL ADDRESS	MOBILE #		MARTIAL STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED			
RESPONSIBLE PARTY INFORMATION (If other than self)						
LAST NAME	FIRST NAME	MI	HOME #			
ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY #		
EMPLOYER	OCCUPATION		WORK #			
EMPLOYER'S ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY ☐ SPOUSE ☐ SON ☐ DAUGHTER		
MOTHER'S NAME	MOTHER'S BIRTHDATE	FATHER'S NAME		FATHER'S BIRTHDATE		
EMPLOYMENT INFORMATION						
PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT	OCCUPATION	EMPLOYMENT OR STUDENT STATUS: ☐FULL-TIME ☐PART-TIME ☐SELF EMPLOYED ☐NOT EMPLOYED ☐ACTIVE MILITARY ☐RETIRED				
PATIENT'S EMPLOYER OR SCHOOL ADDRESS						
CITY	STATE	ZIP				
EMERGENCY INFORMATION						
NAME	RELATIONSHIP	HOME #				
ADDRESS	CITY	STATE	ZIP	WORK #		
INSURANCE INFORMATION ☐ PPO ☐ POS ☐ MEDICARE ☐ HMO CO-PAY $						
PRIMARY INSURANCE	SOCIAL SECURITY #	CARDHOLDER		DATE OF BIRTH		
GROUP NUMBER	IDENTIFICATION NUMBER		EFFECTIVE DATE			
ADDRESS	CITY	STATE	ZIP	PHONE NUMBER		
SECONDARY INSURANCE	CARDHOLDER		DATE OF BIRTH			
GROUP NUMBER	IDENTIFICATION NUMBER		EFFECTIVE DATE			
ADDRESS	CITY	STATE	ZIP	PHONE NUMBER		
PHARMACY INFORMATION-Must provide complete address information to ensure your prescriptions are sent to the correct pharmacy.						
PHARMACY NAME	PHARMACY PHONE NUMBER					
ADDRESS	CITY	STATE	ZIP			

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

I hereby authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance, and other health plans to Integrated Dermatology of Fairfax, LLC of any medical benefits payable to me for the services provided at Integrated Dermatology of Fairfax, LLC. I also authorize the release of all medical information necessary to process insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claims processing or as long as dictated by payor. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance deemed patient responsibility by the insurance company. I understand it is my responsibility to pay the balance in full if the insurance information provided proves false or otherwise ineffective. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

Please be aware our office is not liable for any lab bills. It is a patient's responsibility to inform our office of which lab your insurance company has a contract with.

FEES

I also understand that if I do not cancel my appointment within 24 hours of my appointment time, I am subject to a $100 fee for exam visits and $150 fee for surgical or cosmetic visits.

X_____

Patient Signature or Signature of Guardian or Parent Date

MEDICARE PATIENTS ONLY - Lifetime Signature on File and Lifetime Consent

I request that payment of authorized Medicare benefits be made on my behalf to Integrated Dermatology of Fairfax, LLC. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related services. I request that payment of authorized Medigap or secondary insurance benefits be made on my behalf to Integrated Dermatology of Fairfax, LLC. .

X_____

Signature of Beneficiary Medigap Insurer Medigap # Date

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(703) 352-2620 • (703) 352-2594 Fax