PATIENT REGISTRATION FORM

PATIENT INFORMATION ☐ Mr. ☐ Mrs. ☐ Ms.	First Name:	MI:	Last Name:
Address:		City/State/Zip:	
Nickname:	Date of Birth:	Sex: ☐ Male ☐ Female	Social Security Number:
Home Phone:	Work Phone:	Cell Phone:	E-Mail:
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed			
Family Doctor:		Family Doctor Phone No.	
Referring Doctor if Different:		Referring Doctor Phone No.	

INSURANCE HOLDER (If other than patient) ☐ Mr. ☐ Mrs. ☐ Ms.	First Name:	MI:	Last Name:
Address:		City/State/Zip:	
Home Phone:	Work Phone:	Ext:	
Date of Birth:	Sex: ☐ Male ☐ Female	Social Security Number:	Relationship to Patient:

GUARANTOR (If other than patient) ☐ Mr. ☐ Mrs. ☐ Ms.	First Name:	MI:	Last Name:
Address:		City/State/Zip:	
Home Phone:	Work Phone:	Ext:	
Date of Birth:	Sex: ☐ Male ☐ Female	Social Security Number:	Relationship to Patient:

OTHER INFORMATION

Pharmacy Name & Location:	Phone Number:
Emergency Contact Name & Relationship:	Phone Number:

CONSENT FOR MEDICAL TREATMENT OF A MINOR

I (we) the undersigned parent, parents, or legal guardian of a minor, do hereby authorize and consent to any medical exam or treatment rendered under the general or special supervision of a duly licensed physician, licensed under the provisions of the laws in the State of Indiana. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required but is given to provide authority and power to render care, which the aforementioned physician in the exercise of his best judgement may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

FINANCIAL RESPONSIBILITY STATEMENT:
If no insurance is to be filed by Dawes Fretzin Dermatology Group, full payment is due at time of service. Co-payments, co-insurance and non-covered services are due at time of service as well. A $50.00 fee will be assessed for missed surgical and Blu light appointments without 24 hour notice. A $25.00 fee will be assessed for missed appointments without 24 hour notice and for returned checks.

The undersigned acknowledges that in the event this account is turned over for collection, I will be responsible for the costs of collection which includes, but is not limited to, collection agency fees, reasonable attorney's fees, court costs, witness costs and prejudgment interest at 8% per annum. Each party further agrees that the Marion County Circuit, Superior, or Small Claims Court shall be the proper court of jurisdiction and venue. Further, each party waives trial by jury.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND TO RELEASE INFORMATION:
I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I also authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

I acknowledge receipt of a copy of Notice of Privacy Practices.

Date:		Patient Signature (Parent/Guardian):	
Date:		Patient Signature (Parent/Guardian):	
Date:		Patient Signature (Parent/Guardian):	