QUARLES DERMATOLOGY

Specializing in Diseases of the Skin, Hair, and Nails

PATIENT REGISTRATION FORM - 03/10/2011

PATIENT INFORMATION

Last Name:		Referred by:		Home Phone:	
First Name:		Birth Date:		Work Phone:	
Middle Intial:		SSN:		Cell Phone:	
Address:		License:		Pager:	
City:		Sex:		Email:	
State:	Zip Code:	Marital Status:			

GUARANTOR INFORMATION

Name:		Birth Date:		Home Phone:	
Address:		SSN:		Work Phone:	
City:				Cell Phone:	
State:				Pager:	
Zip Code:				Email:	

INSURANCE INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
Employer:		
Insurance Carrier:		
Insured Person:		
DOB:		
Group or FECA Number:		
Member Id:		

HOW DID YOU HEAR ABOUT US?

Internet	Newspaper	Friend	Radio	TV	Ins. Co	Dr.	Phonebk	Prev Pat.	Family
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other:

I hereby agree to treatment by Quarles Dermatology as is necessary of this practice. I agree to be responsible for the charges for services rendered, and authorize the release of any medical information necessary for processing insurance claims by Quarles Dermatology I also authorize and assign all insurance benefits directly to the named doctor, the amount due me in my pending claim for Medical or Surgical treatment or services by reason of such treatment or service rendered to me. A copy of this authorization shall be valid as the original. Our handling of insurance is a gratuity only and I agree to be responsible for the debt not paid by insurance company regardless or any reason or mistake in processing. I agree pay court costs, all cost of collection including 33 1/3% attorney fees and interest of 1.5% per month on all unpaid balances due after 30 days. I also agree to pay any missed appointment fees for the appointments not cancelled with at least a 24 hour advance notice.

Signed _____ Date _____