DERMATOLOGY SPECIALISTS OF NORTH ATLANTA, P.C.

PATIENT REGISTRATION

NAME _____
LAST FIRST MIDDLE

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

DATE OF BIRTH _____ **SOCIAL SECURITY#** _____

HOME # _____ **WK #** _____ **CELL #** _____

E-MAIL ADDRESS _____

INSURANCE CO. NAME _____

POLICY # _____ **GROUP #** _____

POLICY HOLDER NAME _____

SOCIAL SECURITY# _____ **DATE OF BIRTH** _____

I understand that it is my responsibility to verify that Dermatology Specialists of North Atlanta, P.C. is a provider of my insurance plan before I present to the office for treatment. I agree to obtain a referral from my primary care physician if required by my insurance company. Any charges from Dermatology Specialists of North Atlanta, P.C. not paid by my insurance company will be my sole responsibility. I authorize the release of medical information to my primary care or referring physician, to consultants, or to my insurance company (ies) as necessary to process insurance claims, insurance applications and exchange of information needed for my medical care. I authorize payment of medical benefits to Dermatology Specialists of North Atlanta, P.C. for any professional services rendered to my dependent or me. I agree to pay in advance for all services unless my insurance is filed. If my insurance is filed, I will pay my applicable co-pay and/or deductible in advance of my visit. I understand that payment is accepted in the form of cash, check, credit card or debit card. A photocopy of this assignment is as valid as an original. I understand that I am financially responsible for all charges whether or not they are paid by my insurance.
My signature below signifies my understanding and willingness to comply with these policies.

PATIENT/LEGAL GUARDIAN: _____ **DATE:** _____