NEW ENGLAND DERMATOLOGY & LASER CENTER

FOR OFFICE USE ONLY	
ACCOUNT NO.	❑ MAB, M.D.
	❑ GPG, M.D.
	❑ SFG, M.D.
DATE	❑ RAI, M.D.
	❑ ALL, M.D.
	❑ RSN, M.D.
INPUT BY	❑ AMS, M.D.
	❑ NPW, M.D.
	❑ DB, PA-C
UPDATE & DATE	❑ HBC, PA-C
	❑ ML, PA-C
	❑ CLO, PA-C

PLEASE PRINT

PATIENT REGISTRATION. . . . .

NAME: ____
LAST FIRST MI

PREFERRED NAME: ______________________________

ADDRESS: ____
STREET OR P.O. BOX

____
CITY STATE ZIP CODE

EMPLOYER: ______________________ OCCUPATION: ______________________

HOME PHONE: ( ) ______-____________ WORK PHONE: ( ) ______-____________ EXT. __________

E-MAIL ADDRESS: ____

SEX: ❑ M ❑ F SOCIAL SECURITY NUMBER: ______-______-______ DATE OF BIRTH: ______ / ______ / ______
MONTH DAY YEAR

PRIMARY CARE PHYSICIAN ______________________ CITY/STATE ______________

REFERRING PHYSICIAN ______________________ CITY/STATE ______________

COLLEGE STUDENT: ❑ FULL TIME ❑ PART TIME NAME OF SCHOOL: ______________

EMERGENCY CONTACT: ______________ RELATIONSHIP: __________ PHONE #: __________

SEND BILL TO: (IF DIFFERENT FROM PATIENT)

NAME: ____
LAST FIRST MI

ADDRESS: ____
STREET OR P.O. BOX

____
CITY STATE ZIP CODE

HOME PHONE: ( ) ______-____________ RESPONSIBLE PARTY'S RELATIONSHIP TO PATIENT: ❑ spouse ❑ parent ❑ other

INSURANCE INFORMATION. . . . .

PRIMARY INSURANCE COMPANY NAME: ______________________ COPAY $ __________

DOES YOUR INSURANCE REQUIRE YOU TO HAVE A REFERRAL: ______________________

NAME OF POLICY OWNER ____
LAST FIRST MI

IDENTIFICATION NO.: ______________________ GROUP NO.: ______________________

RELATIONSHIP TO POLICY OWNER: ❑ self ❑ spouse ❑ parent ❑ other POLICY OWNER'S DATE OF BIRTH _____ / _____ / _____

SECONDARY INSURANCE COMPANY NAME: ______________________ COPAY $ __________

DOES YOUR INSURANCE REQUIRE YOU TO HAVE A REFERRAL: ______________________

NAME OF POLICY OWNER ____
LAST FIRST MI

IDENTIFICATION NO.: ______________________ GROUP NO.: ______________________

RELATIONSHIP TO POLICY OWNER: ❑ self ❑ spouse ❑ parent ❑ other POLICY OWNER'S DATE OF BIRTH _____ / _____ / _____

PLEASE PRESENT YOUR INSURANCE CARDS TO THE RECEPTIONIST SO COPIES MAY BE MADE.

PATIENT CONSENT FOR TREATMENT, PAYMENT, TO SHARE HEALTH INFORMATION FOR LIMITED PURPOSES, AND FOR PHOTOGRAPHS

ALL PATIENTS:

- I hereby authorize medical/surgical treatment, care and/or services by New England Dermatology & Laser Center.
- I hereby authorize payment directly to New England Dermatology & Laser Center for all medical/surgical benefits, if any, that may be payable to me under the terms of my health insurance policy.
- I fully understand that I am primarily and financially responsible for fees incurred. I further understand that payment to New England Dermatology & Laser Center is not contingent on any settlement, judgment, or verdict by which I eventually recover medical fees.
- I hereby consent to and authorize New England Dermatology & Laser Center to use and disclose any of my health information, including my medical records, for purposes concerning my treatment, payment for health care provided to me, or the health care operations of New England Dermatology & Laser Center or other treating health care provider or plan.

Signature of patient or guardian: ____Date:________________

MEDICARE PATIENTS ONLY:

I authorize any holder of medical and other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment or benefits apply.

Signature of patient or guardian: ____Date:________________

MEDICARE SUPPLEMENTAL:

If you have a supplemental policy in which Medicare automatically crosses over to, we are required to keep a separate signature on file. I request authorized supplemental policy benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

Signature of patient or guardian: ____Date:________________

PHOTOGRAPHS:

I give New England Dermatology & Laser Center permission to take clinical photographs for my medical record, and understand that the photographs remain the property of the office.

☐ YES ☐ NO

I give permission for these photographs to be used for the purpose of furthering medical education.

☐ YES ☐ NO

Signature of patient or guardian: ____Date:________________