PATIENT REGISTRATION

☐ Mr. ☐ Mrs. ☐ Sr. ☐ Jr.

☐ Ms. ☐ Miss _____ _____ _____ _____

First Name Middle Initial Last Name Name Preference

_____

Street Address

_____

City State Zip

Home Phone: (_____)_____ Work Phone: (_____)_____ Ext: _____

Cell Phone: (_____)_____ Email: _____

Contact Preference for Appointment Confirmations (Please Check One): ☐ Text ☐ Email ☐ Phone

Date Of Birth: _____ Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Other

SSN: _____ Race: ☐ White ☐ Black/African American ☐ Amer. Indian ☐ Asian ☐ Hispanic ☐ Other

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino Primary Language: _____

Primary Care Physician: _____ Phone: (_____)_____

Referred By: _____ Phone: (_____)_____

PHARMACY

Name: _____ Street/Zip Code: _____ Telephone #: (_____)_____

PRIMARY INSURANCE INFORMATION

Insurance Company: _____

Insured Party Information: Relationship To Insured Party: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ Email: _____

Date Of Birth: _____ SSN: _____ Sex: ☐ Male ☐ Female

Employer Name: _____

Insured I.D: _____ Group Number: _____

SECONDARY INSURANCE INFORMATION

Insurance Company: _____

Insured Party Information: Relationship To Insured Party: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Date Of Birth: _____ SSN: _____ Sex: ☐ Male ☐ Female

Employer Name: _____

Insured I.D: _____ Group Number: _____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. **Payment is expected from you, at the time of service, for "your part" of the charges.** The policy of this office is that the parent who accompanies the patient is responsible for all fees for service rendered (only that parent will be billed). We accept Visa, MasterCard, and Discover for your convenience. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the physician to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the physician when an assigned claim is filed. A patient may be charged a service fee for any missed appointments or for repeated cancellations within twenty-four hours of the appointment time. The fee charged will be determined by the time allotted for the appointment. In the event that your account must be turned over to collections, you will be responsible for any additional fees added to your account. If your check is returned to us as unpaid, $35 will be assessed to your account. Additionally, **I acknowledge that I have received a copy of Jason B. Amato, M.D. Dermatology, LLC's Notice of Privacy Practices:**

Patient/Guardian Signature* _____ Date _____

*(Signature of Guardian, *Only If Patient Is A Minor*)