PATIENT REGISTRATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ____ ☐ Sr. ☐ Jr.

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*)