

SOUTHWEST DERMATOLOGY

410 W. Main.
Ottawa, IL 61359
815-434-7231

REGISTRATION (PLEASE PRINT)

(PATIENT'S INFORMATION)

Last Name _____
First Name _____ Middle Initial _____
Address _____
City _____
State _____ Zip _____
Home Phone (_____) _____ Work / Cell (_____) _____
Patient's Birth Date _____ Sex: M _____ F _____
Patient's SS # _____
Do you have Medical Insurance? No _____ Yes _____ If yes,
Name of Primary Insurance _____
Responsible Party (for this account) _____
Address _____
City _____ State _____ Zip _____
Responsible Party's SS # _____ Birthdate _____
Patient's Marital Status: Single Married Widowed Separated Divorced
Relationship to Insured _____
Name of Primary Insurer _____
Policy # _____ Group # _____
Name of Secondary Insurer (if any) _____
Policy # _____ Group # _____
Emergency Contact _____ Phone _____
How did you learn of our practice? _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company
and assign directly to Dr. _____ all medical benefits, if any, otherwise payable to me
for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor
to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. _____
for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing
Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature
requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance"
is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releas-
ing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of
the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered ser-
vices. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature

Date