Initial Patient Registration Information

Patient Name: ____ Date of birth: _____/_____/___________

Gender: ▢ M ▢ F Preferred Name: ______________________ E-mail:____

Address: __________________________________Unit/Suite#_________ City, State, Zip: ____________________________________

Preferred Phone: __ __ __-__ __ __ - __ __ __ __ Cell / Home / Work Ok to leave detailed message? ▢ Yes ▢ No

Alternate Phone: __ __ __-__ __ __ - __ __ __ __ Cell / Home / Work Ok to leave detailed message? ▢ Yes ▢ No

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Responsible Party: Name___________________________________ Date of birth: _____________ Relation: ___________________
First Middle Last

Address (if different from patient): _____________________________Unit/Suite#_________ City, State, Zip: _______________________

Preferred Phone: __ __ __-__ __ __ - __ __ __ __ Cell / Home / Work Ok to leave detailed message? ▢ Yes ▢ No

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How may we remind you of appointments: ▢ E-Mail ▢ Text Message ▢ Do Not Remind

If you have results or need to be contacted, at which number may we leave a message to return our call? *Check all that apply* ▢ Home ▢ Cell ▢ Work ▢ none*

*please discuss with the physician how to best contact you

This authorization allows Market Street Dermatology to discuss all aspects of my protected health information with the individual(s) listed below:

Name: __________________________________ Relation: ___________________ Phone number: ______________________________

Name: __________________________________ Relation: ___________________ Phone number: ______________________________

Centers for Medicare and Medicaid Services require us to ask all patients (regardless of insurance type).

Is English your primary language? ▢ Yes ▢ No If no, What is your primary language? ____________________

What is your race?
▢ American Indian or Alaskan Native
▢ Asian
▢ Black or African American
▢ White or Causasian
▢ Native Hawaiian or other pacific
▢ Other ▢ Decline

What is your ethnicity?
▢ Hispanic or Latino
▢ Not Hispanic/Latino

Please initial each line item and sign below:

Initial:_______ Records Release and Assignment of Benefits: I authorize the release of my health information by Market Street Dermatology for the purposes of my current treatment, including release of information to my referring or primary care provider and other health care providers participating in my current treatment. I authorize the release of medical information by Market Street Dermatology (including billing information) as necessary for payment purposes to my insurance company, the responsible party named above, and any other person or entity responsible for payment for my medical treatment. I authorize payment of medical benefits to Market Street Dermatology for services rendered to myself and/ or dependent.

For Medicare subscribers ONLY:

Initial:_______ Medicare Authorization: I request that payment of authorized Medicare benefits be made on my behalf to Market Street Dermatology for any services furnished me by that physician / clinic / supervisor. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Initial:_______ MEDIGAP: I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits payable for related services.

I understand I may refuse to sign this authorization and realize that this may result in a delay of treatment and/or have potential adverse health consequences. This authorization will expire in one year from the date signed; however, I may change or revoke it at any time.

Patient or Responsible Party Signature ______________________________________ Date ____/_______/______

My signature indicates that I have received and/or reviewed a copy of my physician's Notice of Privacy Practices. I understand that I may request a paper version of this policy and that it is available to me on the website and in the office.

Patient or Responsible Party Signature __________________________________ Date ____/_______/______