Patient Registration Form

Hudson DERMATOLOGY
to know. to diagnose. to heal.

First | Middle | Last | ◯ Jr. ◯ Sr.

Prefer to be called | Title: ◯ Mr. ◯ Mrs. ◯ Ms. ◯ Miss ◯ Dr.

Address | Apt. # | City | State | Zip

Home Phone | Mobile Phone | Work Phone

Date of Birth (mm/dd/yyyy) | Social Security Number | Gender: ◯ Male ◯ Female

Employer | Address

If Student: ◯ Full Time ◯ Part time | Email Address

Spouse , | Spouse/Partner Date of Birth (mm/dd/yyyy) | Who referred you?

In order to establish optima 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. WE ACCEPT VISA® AND MASTERCARD® FOR YOUR CONVENIENCE.** Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service.

Signature of patient or legal guardian | Date

Name of policy owner if other than patient | Patient relationship to policy owner: ◯ Self ◯ Child ◯ Other

Should the account fall into arrears greater than 60 days, I authorize that the unpaid balance to be charged to my major credit card as listed below.

Please present insurance cards and photo ID to the receptionist so copies may be made.
No email, or electronic copies will be accepted, or original copies.

Do we have your permission to:

Leave a message on your cell phone?	◯ Yes	◯ No
Leave a message on your answering machine at home?	◯ Yes	◯ No
Leave a message on your place of employment?	◯ Yes	◯ No
Discuss your medical condition with any member of your household?	◯ Yes	◯ No

If yes, whom? | Relationship

Signature of patient or legal guardian | Date

Please be advised: We **DO NOT** provide treatment for Workers' Compensation Claims. If you have a skin problem due to your work, you should report the problems to your employer who will direct your care to a Bureau of Workers' Compensation (BWC) Provider with a special Workers' Comp. identification card. If your employer refuses to cooperate, call the Bureau of Workers' Compensation and they can direct your actions. Their number is 1-800-644-6292 or 330-643-3111. The Bureau can tell you the names of BWC participating physicians.

Primary Insurance

$ Office Co-Pay

Insured's Name

Relationship to Patient

Home Address | Apt. # | City | State | Zip

Home Phone | Mobile Phone | Work Phone

Date of Birth (mm/dd/yyyy) | Social Security Number

Employer | Employer Address

Secondary Insurance

$ Office Co-Pay

Insured's Name

Relationship to Patient

Home Address | Apt. # | City | State | Zip

Home Phone | Mobile Phone | Work Phone

Date of Birth (mm/dd/yyyy) | Social Security Number

Employer | Employer Address

FINAL BILLING ADDRESS IF DIFFERENT FROM PATIENT OR INSURED

Name

Relationship to Patient

Home Address | Apt. # | City | State | Zip

Home Phone | Mobile Phone | Work Phone

List skin problem you are seeking care for and body area involved

List medications you are taking

List medications you are allergic to

List any history of allergies

Did you see another physician for this problem? ◯ No- ◯ Yes Dr.

Physician's Address

Did he/she refer you? ◯ No ◯ Yes