

DERMATOLOGY ASSOCIATES

Patient Registration and Consent for Treatment
(please print)

Last Name First Middle Initial

Mailing Address City State Zip

Home Phone Number Cell Phone Number Date of Birth

Social Security Number Email Address

Marital Status: Single Married Divorced Widowed Sex: Male Female

Employment Status: Part-Time Full-Time Retired Student Other _____

EMPLOYMENT INFORMATION

Employer Occupation Work Phone Number

RESPONSIBLE PERSON (If patient is a Minor)

Full Name Relationship Home Phone Number Work/Cell Phone Number

PRIMARY INSURANCE INFORMATION

Policy Holder's Name Date of Birth

Insurance Company Group # Policy #

SECONDARY INSURANCE INFORMATION

Policy Holder's Name Date of Birth

Insurance Company Group # Policy #

RELEASE OF INFORMATION

I hereby authorize release of my medical information to the following person(s):

1. _____
Name Relationship

2. _____
Name Relationship

3. _____
Name Relationship

GENERAL CONSENT FOR TREATMENT

I consent to receive medical treatment, including procedures rendered by DAS. Specific surgical procedures may require additional consent from you as determined by Dr. Collins or his staff.

FINANCIAL RESPONSIBILITY

I understand that regardless of insurance payment, I am ultimately responsible for payment for healthcare services rendered by DAS.

Patient/Responsible Party Signature Date Witness Date