# 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