THE SKIN INSTITUTE

Patient Registration Form

JOSEPH R. TERRACINA, M.D.

Today's Date ____/____/____

(Please Print)

PATIENT INFORMATION

Name ____
Last First M.I.

Address ____
City State Zip

Home Phone __________________________ Work Phone ________________________ SS# ______________________________
Area Code Area Code

Date of Birth _____/_____/_____ Age ______ Sex _______

RESPONSIBLE PARTY (if different from patient)

Name ____
Last First M.I.

Address ____
City State Zip

Home Phone __________________________ Work Phone ________________________ SS# ______________________________
Area Code Area Code

Date of Birth _____/_____/_____ Age ______ Sex _______

INSURANCE INFORMATION (Please present insurance card at time of check in.)

Primary Insurance Name ___________________________

Ins. Address _____________________________________

Name of Insured __________________________________

Insured's ID# ____________________________________

Group # ____

Relationship of patient to the insured __________________

Employer Name ___________________________________

Employer Address _________________________________

Employer Phone __________________________________
Area Code

Secondary Insurance Name___________________________

Ins. Address _____________________________________

Name of Insured __________________________________

Insured's ID# ____________________________________

Group # ____

Relationship of patient to the insured ______________________

Employer Name ___________________________________

Employer Address _________________________________

Employer Phone __________________________________
Area Code

Other family members that are patients ____

Pharmacy of choice ____ Phone ________________________

In case of Emergency, who should be notified? ____ Phone ________________________

Referred by: ____

Primary Care Physician ____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient Signature ______________________________________ Date _____/_____/_____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check, or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and copayments. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature ______________________________________ Date _____/_____/_____