REGISTRATION

NAME_____
First Middle Initial Last

Please Circle (as on insurance coverage): Male Female Single Married Divorced Widowed

ADDRESS

Street _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Email: _____

Communication regarding upcoming appointments and account balances are sent via email and text

Date of Birth _____/_____/_____ Spouse's Name _____

Occupation_____Family Doctor _____

Name of Person Responsible for Payment _____

Address if different than above _____

MEDICAL INSURANCE

PRIMARY Insurance Company _____

Membership # _____ Group # _____ Copay _____

Name of Policy Holder _____ Date of Birth _____/_____/_____

Relationship of Patient to Policy Holder Circle One: SELF SPOUSE CHILD OTHER _____

SECONDARY Insurance Company _____

Membership # _____ Group # _____ Copay _____

Name of Policy Holder _____ Date of Birth _____/_____/_____

Relationship of Patient to Policy Holder (Circle One) SELF SPOUSE CHILD OTHER _____

If Medicare is secondary insurance, circle reason- Disabled under age 65/ Still working/Other-specify_____

REFERRED TO THIS OFFICE BY _____

- **IF WE NEED TO CALL YOU ABOUT YOUR MEDICAL CONDITION, WHICH SHOULD WE DO?**
  - Call you at WORK _____ Call you at HOME _____ Either _____
  - Other than yourself, may we: Talk to your SPOUSE _____ , and/or
  - Name(s): _____ Please INITIAL _____

I authorize release of any medical information necessary to process this claim. I authorize payment of medical benefits to Robinson & Max Dermatology PA.

SIGNED _____DATE _____

PAYMENT IS EXPECTED AT THE TIME OF VISIT.
WE WILL BE HAPPY TO ASSIST YOU IN FILLING OUT INSURANCE CLAIMS.