

MOSS DERMATOLOGY
REGISTRATION INFORMATION

(Please Print)

Date: _____

Patient: _____
Last Name First Name Mid Initial

Street Address: _____

City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Date of Birth: _____ Single Married Divorced Separated Widowed

Home Phone: _____ Social Security: _____

Occupation: _____ Work Phone: _____ Cell Phone: _____

Spouse/Responsible party (If Minor): _____ Relationship: Mother Father

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security: _____

Name of Primary Insurance: _____

Identification #: _____ Group #: _____

Card Holder: _____ Date of Birth: _____

Name of Secondary Insurance (If Any): _____

Identification #: _____ Group #: _____

Card Holder: _____ Date of Birth: _____

Emergency contact person: _____ Phone #: _____

Purpose of Visit: _____

Referring/Primary Care Physician: _____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered; without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to Dermatology & Gastroenterology Associates all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to Dermatology & Gastroenterology Associates will be credited to my account, in accordance with the above said assignment.

(Authorized Signature of Subscriber) (Date)