Georgia Skin Center
PATIENT REGISTRATION FORM
Please present your insurance cards and your photo ID to the receptionist so copies may be made.

Name: _____☐Jr. ☐Sr. Sex: ☐Male ☐Female
First Middle Last
Marital status: ☐Married ☐Single ☐Wid. ☐Div. ☐Other _____ Social Security #: _____

Address: _____
Street Name City State Zip Code

Home Phone: _____ Date of Birth: _____
Month/Day/Year
Cell Phone: _____ E-mail: _____
*Please circle preferred contact number above.

How did you hear about us? ☐Specialist ☐Primary Care Physician _____
☐Family/Friend ☐Internet ☐Patient in Practice ☐Yellow Pages ☐Newspaper ☐Magazine ☐Skin Screening
☐Insurance Directory ☐Other _____

Spouse Name and Phone #: _____ Spouse's Date of Birth: _____
Month/Day/Year
Insurance Policy Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Policy Holder SSN: _____
Month/Day/Year
Policy Holder Relationship to Patient: _____

Emergency Information (Please list someone who does not live in your household):

Name and Phone #: _____ Relationship: _____

Address: _____
Street Name City State Zip Code

If Patient is a Minor: It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service. Minors must be accompanied by parent or legal guardian.

_____ _____ _____ _____
Signature of Parent or Legal Guardian | Printed Name of Parent or Legal Guardian | Date of Birth | Date

Race:	**Language**	**Ethnicity:**
White	English	Hispanic/Latino
Black/African American	Spanish	Non-Hispanic/Latino
Asian	Other: _____	
American Indian or Native American		
Native Hawaiian/Pacific Islander		

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when assigned claim is filed.

_____ _____
Signature of Patient, Parent, Legal Guardian or POA Date