MURFREESBORO DERMATOLOGY CLINIC, PLC

MINOR PATIENT REGISTRATION FORM

Today's Date_____

Child's Name:_____ Date of Birth _____
First Middle Initial Last

Home Address:_____
Street City State Zip

Home Telephone: _____ Cellular Telephone:_____ School Name:_____

Legal Guardian or Parent:_____ Home/Work Phone:_____

Address (if different):

_____
Steet City State Zip

Primary Insurance:

_____ _____
Insured's Name Insured's Date of Birth

Home Address (if different):

_____
Street City State Zip

Insured's Employer: _____ _____
Name Work Phone Number

Insurance Co. Name: _____ Group# :_____Co-pay Amount $_____

Insured's Social Security #: _____ ID # :_____

Secondary Insurance:

_____ _____
Insured's Name Insured's Date of Birth

Home Address (if different):

_____
Street City State Zip

Insured's Employer: _____ _____
Name Work Phone Number

Insurance Co. Name: _____ Group# :_____Co-pay Amount $_____

Insured's Social Security #: _____ ID # :_____

Physician Referral Information:

Was this appointment made by your child's doctor or at the doctor's request? YES NO

If so, please provide:

Doctor's Full Name: _____ Telephone:_____

Address: _____
Street City State Zip

Emergency Contact:

Name:_____ Telephone_____

Relationship to Child: _____

Authorization and Consent:

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. If you have questions regarding our financial policies, we will be happy to answer them for you.

I authorize my insurance company(ies) to pay benefits directly to Murfreesboro Dermatology Clinic, PLC. I hereby consent to the release of medical information necessary to process any insurance claims and to any other doctor for the continuation of my child's medical care. The information I have provided is accurate to the best of my knowledge. I accept personal responsibility for any and all services in which my child has been proven ineligible for medical benefits. I have read and received "Information Regarding Insurance and Billing." I understand that a photocopy of this release is as valid as the original .

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the copayment at the time of service as well as any charges deemed payable by the insurance company.

_____ _____

Signature of Parent or Legal Guardian Date

Please present insurance cards to the receptionist so copies may be made.

Do we have your permission to:

Leave a message on your answering machine or voice mail at home? YES NO

Leave a message at your place of employment? YES NO

Discuss the patient's medical condition with any member of your household? If yes, whom:_____ YES NO

NOTICE OF PRIVACY PRACTICES RECEIPT

I have (please choose one):

___ received a copy of Murfreesboro Dermatology Clinic's Notice of Privacy Practices.

___ been offered a copy of Murfreesboro Dermatology Clinic's Notice of Privacy Practices but do not want a copy.

_____ _____

Patient's Signature (or Guardian if under 18) Date

Please read and sign the *Information Regarding Insurance & Billing* notice on the following page.