Alamo City Dermatology

Patient Registration Form

First Name: _____ ***Middle:*** _____ ***Last Name:*** _____

Address: _____ ***City:*** _____ ***State***_____ ***Zip Code:***_____

Date of Birth: _____ ***SSN:*** _____ ***Phone Number:*** _____

Email: _____ ***Ok to leave a message? ☐ Yes ☐ No***

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Legally Separated

Gender Identity: ☐Declined to say ☐ Male ☐ Female ☐ Transgender Male (Female to Male)
☐Transgender Female (Male to Female) ☐Non-Binary Gender ☐Other

Preferred Language: ☐English ☐Spanish ☐ Other: _____

Race: ☐Caucasian ☐African American ☐ Asian ☐ Native American ☐ Other

Ethnicity: ☐ Unspecified ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Other

Insurance

Do you have medical insurance coverage? ☐Yes ☐No
Does your insurance card state "referrals required?" ☐ Yes ☐ No
☐HMO ☐PPO ☐ Private Pay ☐ POS ☐ Medicare Advantage ☐Other

Primary Insurance Name: _____ **Subscriber ID#:** _____ **Group #**_____

Secondary Insurance Name: _____ **Subscriber ID#:** _____ **Group #**_____

Tertiary Insurance Name: _____ **Subscriber ID#:** _____ **Group #**_____

Are you in Hospice Care or Nursing Home? ☐ Yes ☐ No
Name of Agency: _____ Name of Provider: _____ Phone Number: _____

Primary Care Doctor

Name of Primary Care Doctor:	Phone Number:
Name of Referring Doctor:	Phone Number:

Pharmacy

Pharmacy Name:	Phone Number:
Pharmacy Street Address:	Zip Code:

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Financial Policy

All services rendered are charged to the patient or authorized individual. The patient or authorized individual is responsible for payment regardless of insurance coverage.
Full payment is expected at the time of each visit. In all instances when the patient is covered by a health insurance company with whom this office is a participating provider, we will verify eligibility and benefits directly with the insurance company. Please notify our office if your insurance has changed at least **24 hours** prior to your appointment. If we are not a provider with your new insurance, you will be treated as a private pay patient.

It is ultimately the responsibility of your insurance company to provide the education on the benefits available to you. All co-payments, coinsurance, and deductibles are due at the time services are rendered.

I hereby authorize Alamo City Dermatology to release medical information concerning my examination and/or treatment for insurance purposes and receive direct payment for medical benefits payable to me for the services rendered. I, the undersigned, have completed this registration form to the best of my knowledge. Furthermore, I have read and fully understand the payment policy & authorization of payment outlined above.

☐I understand that if I need letters or medical records for my personal use, I will get charged a fee according to the office policy.

Signature of Patient or Authorized Individual: _____ Date: _____

Cancelation Policy / No Show Policy

We understand that a situation may arise in which you must cancel or reschedule your appointment. Please give us the courtesy of calling no less than **24 hours** in advance to reschedule your appointment. Failure to do so will result in a missed appointment fee, NOT charged to your insurance.

For medical procedures, a $25.00 fee can be incurred if you:

1.) Do not show for your scheduled appointment
2.) Or do not notify our office 24 hours prior to canceling your scheduled appointment.

For cosmetic procedures, a $50.00 fee can be incurred if you:

1) Do not show for your **cosmetic** appointment
2) Or do not notify our office 24 hours prior to canceling your scheduled appointment.

Signature of Patient or Authorized Individual: _____ Date: _____

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Consent to Treatment and Payment

I, _____, voluntarily consent to the rendering of health care services and medical treatment by authorized staff of Alamo City Dermatology for myself and/or above stated patient. I also authorize my insurance companies to reimburse Alamo City Dermatology for services rendered. I understand that I am responsible for all charges in connection with the care and treatment rendered. I also understand that all payments including deductibles and copays are due at time of service.

Signature of Patient or Authorized Individual: _____ Date: _____

OTHER

How did you hear about us?

Referred by: DR._____

☐Family Member / Friend

☐Google

☐Yelp

☐Website

☐Social Media Platform (Facebook, Instagram, Yelp, Twitter, other).

Are you interested in discussing any cosmetic treatments during your visit?
☐Yes ☐No

Are you interested in being featured on our social media platforms?
☐Yes ☐No

Connect with us!

@alamocitydermatology