REGISTRATION FORM

PATIENT INFORMATION

Patient/Child First Name: MI: Last Name:	Age:	Date of Birth:	Gender: ☐ Male ☐ Female

Ethnicity? ☐ Refused ☐ Not Hispanic ☐ Hispanic	Language Spoken? ☐English ☐ Spanish ☐Other Race? ☐ White ☐ Asian ☐ Black ☐ Hispanic ☐ Indian/Native ☐ Other	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Mailing address:			
City:	State:	Zip Code:	Social Security #(last 4 required):

Home: Cell: Work: For Appointment Reminders and Lab Results:

☐ Text Message ☐ Voice Message Preferred Number:

Email Address: ☐I do not have access to email

PARENT/GUARDIAN (IF PATIENT IS A MINOR) AND INSURANCE INFORMATION

(Please give your insurance card to the receptionist to be scanned. We are not responsible for filing claims if no card is on file)

Parent/Guardian Name:	Birth date:	Address (if different): ☐ Same as above	Preferred phone #: ( )
Social Security #(required):	Employer:		Work/Cell phone #: ( )

Is the patient covered by insurance? ☐ Yes ☐ No **Primary Physician**:

Name of primary insurance ☐Medicare ☐ NC Medicaid ☐ BCBS ☐Other	Policy #:

Name on the insurance card? :	SS # of the policy holder(required):	Birth date of Policy Holder:	Group #:	Co-payment: $

How is the patient related to the policy holder? :
☐ Self(or Medicaid) ☐ Child (covered under parent's insurance) ☐Spouse ☐ Other

Name of secondary insurance ☐None	Policy Holder: ☐Same as primary	Date of Birth	Policy #:
Patient's relationship to subscriber:	☐Self(Medicaid) ☐ Child(covered under parent's insurance) ☐ Spouse ☐ Other		

IN CASE OF EMERGENCY

Contact Name:	Relationship to patient:	Home phone #: ( )	Work phone #: ( )

By signing below, I certify the above information to be true and accurate. I authorize my insurance to be filed and benefits be paid directly to the physician/practice. I understand that I am responsible for understanding my insurance coverage/benefits *and any balances not covered/left after insurance*. I also authorize Biltmore Dermatology Associates, PA and/or my insurance company to release any information required to process my claims. In addition, Biltmore Dermatology Associates, PA may contact me by telephone at any number contained in my records, including wireless telephone numbers, for the purposes of communicating with me about my health care, servicing my account and collecting amounts due. Methods of contact may include pre-recorded voice messages and text messages. I understand that I may revoke this consent at any time by calling or writing to Biltmore Dermatology Associates, PA.

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Signature of Patient Date