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: ☐ingle ☐arried ☐idowed ☐ivorced	
Mailing address:		Social Security #(last 4 required): Driver License#:	

City:	State:	Zip Code:	Home Phone:	Cell Phone:	Work Phone:

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.