DERMATOLOGY ASSOCIATES OF SAVANNAH

Patient Registration and Consent for Treatment

(please print)

Last Name _____ First _____ Middle Initial _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone Number _____ Cell Phone Number _____ Date of Birth _____

Social Security Number _____ Email Address _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

EMPLOYMENT INFORMATION

Employer _____ Occupation _____ Work Phone Number _____

RESPONSIBLE PERSON (If patient is a Minor)

Full Name _____ Relationship _____ Home Phone Number _____ Work/Cell Phone Number _____

PRIMARY INSURANCE INFORMATION

Policy Holder's Name _____ Date of Birth _____

Insurance Company _____ Group # _____ Policy # _____

SECONDARY INSURANCE INFORMATION

Policy Holder's Name _____ Date of Birth _____

Insurance Company _____ Group # _____ Policy # _____

RELEASE OF INFORMATION

I hereby authorize release of my medical information to the following person(s):

1. _____ Name _____ Relationship

2. _____ Name _____ Relationship

NO SHOW POLICY

If an appointment is missed, there will be a $35.00 no show fee billed to the patient. Please notify our office at least 48 hours in advance so that we can accommodate our other patients.

GENERAL CONSENT FOR TREATMENT

I consent to receive medical treatment, including procedures rendered by DAS. Specifc surgical procedures may re - quire additional consent from you as determined by Dr. Collins or his staff.

FINANCIAL RESPONSIBILITY

I understand that regardless of insurance payment, I am ultimately responsible for payment for healthcare services rendered by DAS.

Patient/Responsible Party Signature _____ Date _____ Witness _____ Date _____