THE DERMATOLOGY SPECIALISTS

Patient Registration

Date: _____

Patient Information (please complete using your name as listed on your insurance card)

First Name:_____Middle Initial:_____Last Name: _____
Address:_____Apt/Floor:_____City:_____State: Zip Code: _____
Home Phone:_____Cell Phone:_____Work Phone: _____
Date of birth:_____SS#_____Email:_____
Sex: M_____F_____Occupation:_____Employer: _____

Insurance Responsibility – Policy holder Information. If patient is policyholder, please disregard this section.

First Name:_____Middle Initial:_____Last Name: _____
Address:_____Apt/Floor:_____
City:_____State: _____Zip Code: _____
Home Phone:_____Cell Phone:_____Work Phone: _____
Email Address: _____
Date of birth:_____SS#_____Sex: M_____F_____
Occupation:_____Employer: _____

Insurance Information
All Patients must provide a copy of their insurance card at the time of their visits.
Primary Insurance:_____Name of Insured:_____Relationship: _____
Insured's DOB:_____Policy/ID#_____Group # _____
Secondary Insurance:_____Name of Insured:_____Relationship: _____
Insured's DOB:_____Policy #_____Group # _____

Referring Physician Information
Referring Physician:_____Phone # _____
Primary Care:_____Phone # _____

HOW DID YOU HEAR OF OUR OFFICE? _____

AUTHORIZATION FOR MINOR TO BE SEEN WITHOUT GUARDIAN PRESENT: **I**_____**(name)** authorize my child _____ **(minor name)** to be seen and receive treatment at Bobby Buka MD PC without my presence.

Emergency Contact Information
Name:_____Relationship:_____Phone: _____

Credit Card Authorization: You will be asked to leave a credit card number at the time of check in. This information will be stored securely until the time when your insurances have paid their portion and notified us of any member responsibilities. At that time any remaining balance owed will be charged to the card on file. Please note that this will NOT compromise your ability to dispute charges or your insurance company's determination of payment. You may revoke this authorization at any time in writing.
I,_____(name) Authorize Bobby Buka MD PC to charge outstanding balances (max $500 per charge) to the following card:

	CARD NUMBER:	EXPIRATION DATE:	CVV:	BILL ZIP CODE:
VISA				
MASTERCARD				
AMERICAN EXPRESS				

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits of the provider.

Signature:_____ Date: _____