New Patient Registration Form
Midlothian Dermatology

PATIENT INFORMATION ☐ New Patient ☐ Update Today's Date: ________________ Chart #:__________

Name:____ Birthdate: _________________ Age: ________
First Last

Marital Status: _____ ☐ Male ☐ Female ☐ Other _________________ ☐ Preferred Name:__________________________

SSN: ______________________ Occupation: ____________________________

Address: ____
Street City State Zip

☐Home Phone: _____________________ ☐ Work phone: _____________________ ☐Cell: ________________________

******* PLEASE CHECK ONE PREFERRED DAYTIME CONTACT PHONE NUMBER *******

Email Address: ____

PARENT or RESPONSIBLE PARTY *(if different than patient)*

Name: ____ Relationship to patient: ____________________
First Last

Address: ____
Street City State Zip

Home Phone: _______________________ Work phone: ___________________________ Cell: __________________________

INSURANCE

Primary Insurance Name: ____________________________

Subscriber Name: ____________________________________

Subscriber ID #: _____________________________________

Employer's Name: ____________________________________

Relationship of Patient to the Subscriber: __________________

Secondary Insurance Name: __________________________

Subscriber Name: ____________________________________

Subscriber ID #: ______________________________________

Employer's Name: ____________________________________

Relationship of Patient to the Subscriber: _________________

Other family members that are patients: ___________________________ Primary Care Physician: ___________________________

FINANCIAL POLICY and CONSENT FOR TREATMENT

- I authorize Midlothian Dermatology to render treatment to me or my dependents.
- I authorize Midlothian Dermatology to take digital pictures that relate to my care and disclose these if relevant to my care.
- I allow the release of any information including photos relating to my care - or of the person for whom I authorize care- to any insurance company or physician, for the purpose of processing an insurance claim or for any valid medical purpose.
- I authorize my medical insurance company to pay medical benefits directly to Midlothian Dermatology.
- I agree to pay those charges for which I am personally responsible such as co-payments and deductibles on the day of each medical service.
- I understand that returned checks are turned over to the VA Commonwealth Attorney's Office for collection and prosecution.
- I understand there is a $40 charge for returned checks.
- I understand there is a $40 (medical appt)/$100(surgical/cosmetic appt) charge for missed appointments or failure to give 24(medical)/48(surgical/cosmetic) business hours notice for cancellations or rescheduling appointments.
- I understand that it is my responsibility, as policyholder, to contact my insurance company regarding payment of my claim. If payment has not been received from my insurance company within 90 days, I will be billed for the amount due and will be held financially responsible for payment.
- I understand the financial policy and authorize Midlothian Dermatology to charge my credit card on file for any outstanding balances per the financial policy.
- I understand I, THE PATIENT, AM ULTIMATELY RESPONSIBLE FOR ALL PROFESSIONAL FEES.

Your signature below signifies your understanding and willingness to comply with Midlothian Dermatology's financial policies.

Patient or Responsible Party Signature: ____ Date: ________________

STAFF USE ONLY:

Review Date: ____________ Review Date: ____________ Review Date: ____________ Review Date: ____________
Review Date: ____________ Review Date: ____________ Review Date: ____________ Review Date: ____________
Review Date: ____________ Review Date: ____________ Review Date: ____________ Review Date: ____________