Patient Registration

(Please print)

Today's Date: __________________

Patient's Name: ____

Please list your name exactly how it reads on your insurance card

DOB: ___________________________ SSN: __________________________

Mailing Address: ____

City: _________________________ State: __________ Zip: ____________

Contact Number: Primary (_____) _______________________________________

Home Cell Work

Secondary Contact Number: (_____) ______________________________________

Home Cell Work

Emergency Contact: ___________________________ (_____) __________________

(Name) (Phone number)

Responsible Party (if patient is a minor): ____

Primary:

Insurance Carrier name: ____

ID: _______________________________ Group #: ____________________________

Subscriber: Self or ____

Subscriber's Address: (If different than above) _______________________________________

DOB: ____________________ SSN: ____________________________

Secondary:

Insurance Carrier Name: ____

ID: _______________________________ Group #: ____________________________

Subscriber: Self or ____

Subscriber's Address: (If different than above) _______________________________________

DOB: ____________________ SSN: ____________________________

I understand Arkansas Dermatology will only file two insurance carriers and they are to be filed as indicated. I also understand that all copays are due upon check in before services are rendered.
Initial: ___________

Signature: ____

I understand & agree that regardless of the insurance status, I am responsible for the balance on this account for any services rendered. I certify that all the above information is true and correct. I understand it is my responsibility to notify Arkansas Dermatology of any changes in the above information. By not signing, I am agreeing to remit payment in full for all services provided by the staff.

Please complete the information on the back of this form*

Arkansas Dermatology
HIPAA Authorization Form
(Please print)

Date: ________________

Patient's Name: _______________________________________

DOB: __________________________ Email: ____________________________

I, ____ have received a copy of the Arkansas Dermatology Notice of Privacy Practices.

I authorize Arkansas Dermatology to disclose my PHI (Protected Health Information) to the following providers and (or) facilities in regards to my treatment.

Primary Care Provider (PCP):

Name: ________________________________ City: ________________________

Referring Provider:

Name: ________________________________ City: ________________________

Additional Providers or Facilities:

Name: ________________________________ City: ________________________

Name: ________________________________ City: ________________________

(If you do not authorize the release of your information leave the above blank and sign below)

I authorize Arkansas Dermatology to disclose my PHI (Protected Health Information) to any person(s) indicated other than providers. This would include family, friends, guardian, POA……

Name: _________________________________ Phone: ______________________

Name: _________________________________ Phone: ______________________

Name: _________________________________ Phone: ______________________

(If you do not authorize the release of your information leave the above blank and sign below)

Signature: ____

By signing I certify that all the above is true & correct. I understand I have the right to revoke this authorization at any time and that it is my responsibility to request a new HIPAA form to make changes should any occur. By providing an email address, you are consenting to receive communication via unencrypted email.

******Please complete the information on the back of this form*******