# Patient Registration

B·I·L·L·I·N·G·S
Dermatology & Aesthetics

## Patient Information:

First Name:_____MI:_____Last:_____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Age: _____ Social Security: _____ Sex: □ Male □ Female

Mailing Address: _____City:_____State:_____Zip:_____

Home Phone: (  )_____ Mobile Phone: (  )_____

*By providing our office with your mobile/cell phone, you are giving our office permission to call that phone.*

Employer: _____ Occupation: _____ Work Phone: (  )_____

E-Mail Address: _____ Marital Status: □ S □ M □ D □ W Spouse's Name: _____ ___

## Responsible Party (MUST FILL OUT for minors under the age of 18* or legal dependents):

**patients 18 or older will be responsible for all charges incurred regardless of insurance coverage*

First Name:_____MI:_____Last:_____ Employer:_____

Date of Birth: _____/_____/_____ Age: _____ Social Security: _____ Sex: □ Male □ Female

Mailing Address: _____City:_____State:_____Zip:_____

Home Phone: (  )_____ Mobile Phone: (  )_____

## Primary Insurance Coverage (please present insurance card(s) and photo ID):

Insurance Co. Name_____ Policy #_____ Group # _____

Subscriber First Name:_____MI:____Last:_____ Employer:_____

Date of Birth: _____/_____/_____ Age: _____ Social Security: _____ Sex: □ Male □ Female

Mailing Address: _____City:_____State:_____Zip:_____

Patient Relationship to Insured: □ Self □ Spouse □ Child □ Other: _____Phone: _____

### *Office Financial Policy:*

I acknowledge that a copy of Billings Dermatology's Financial Policy has been made available to me and is also available at www.billingsdermatology.com.

Please note: It is important that you understand our financial policies. Read them carefully and contact us with any questions. **Many procedures will result in additional and separate lab charges. Due to the nature of pathology your provider may choose to consult with an offsite lab.** Advise us if your insurance will not cover providers outside of Montana and Wyoming. If you have any insurance or payment concerns, please ask to speak to the office manager. Let us know if medical fees are a true hardship for you.

### *For Montana and Wyoming Medicaid Patients Only:*

I acknowledge this office is not a participant in the Montana or Wyoming Medicaid Program, and I will be responsible for payment for services rendered.

### *Consent to Treatment:*

I voluntarily consent to receive medical and health care services that may include examinations, diagnostic procedures, and treatments.

I understand there are risks inherent to the performance of any surgical procedure such as loss of blood, infection, reaction to anesthesia, numbness and/or lack of sensation, and the formation of thick or otherwise objectionable scars.

I have read the foregoing information and I understand it thoroughly.

_____ _____/_____/_____

Signature of Patient (or guardian) Date