

PATIENT REGISTRATION

PATIENT INFORMATION

Date Completed _____/_____/_____

Full name _____ SS# _____
Last First MIAddress _____ Apt # _____ Gender M F

City/State _____ Zip _____ Birth date _____ Age _____

Marital Status Single Married Divorced Separated Widowed

Daytime Phone _____ Work Phone _____ Cell Phone _____

Pharmacy _____ Primary Care Provider _____

Employer _____ Occupation _____

E-mail _____ Are you a student? Yes No Student Status Full-time Part-time

SPOUSE or PARENT (if patient is a minor)

Full Name _____ Birth date _____
Last First MI

SS# _____ Employer _____ Work Phone _____

Address Same as above _____ City/State _____ Zip _____I give permission to discuss my medical condition with this person Yes No

PERSON RESPONSIBLE FOR PAYMENT

 Check **SELF** if you are 18 years of age or older **AND SKIP THIS SECTION.** SELFFull Name _____ SS # _____
Last First MIBirth date _____ Relationship to patient Spouse Parent Legal Guardian Other

Employer _____ Work Phone _____ Daytime Phone _____

Address Same as above _____ City/State _____ Zip _____

INSURANCE INFORMATION

*Please present your insurance card to the receptionist when you arrive at the clinic, insurance will only be billed if a card is presented.*IN ADDITION TO PROVIDING YOUR INSURANCE CARD, COMPLETE INFORMATION BELOW.INSURED/SUBSCRIBER _____
Last First MI

SUBSCRIBER BIRTH DATE _____

SUBSCRIBER EMPLOYER _____

WHO MAY WE CONTACT IF WE CAN'T REACH YOU:

Full Name _____ Daytime Phone _____
Last First MI

Relationship to patient _____

Address _____ City/State _____ Zip _____

Same as above

I give permission to discuss my medical condition with this person Yes No

ALTERNATE CONTACT

(Please list a person who is not living with you)

Full name _____ Home Phone _____
Last First MI

Address _____ City/State _____ Zip _____

SIGNATURES ARE REQUIRED TO ESTABLISH THE PATIENT ACCOUNT

Please sign both boxes below

ALL PATIENTS (OR GUARANTORS) PLEASE COMPLETE THIS SECTION

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS (Parent or guardian must sign if patient is a minor)

- I authorize the release of any information to my insurance company that they may require for the processing of my claim(s).
- I authorize the release of any medical information for myself or my dependents to consulting or referring physicians.
- I authorize the direct payment of insurance benefits to Deschutes Dermatology Center for services rendered to me or my dependents.
- I authorize treatment by Leslie A. Carter, M.D., Carrie A. Baxter PA-C and staff.
- I authorize Deschutes Dermatology Center to obtain information on the patient's prescription(s) from SureScripts to conduct electronic prescribing.

SIGNATURE _____ DATE _____

ALL PATIENTS (OR GUARANTORS) PLEASE COMPLETE THIS SECTION

OTHER AUTHORIZATIONS

- I have read and understand the Financial Policy. I have been provided a copy for my personal records.
- I authorize the taking of photographs to document my medical condition.
- I authorize the doctor and/or staff to leave messages on my home or cell phone voice mail.
- I authorize the doctor and/or staff to send me e-mail messages at the e-mail address above.
- I would like to receive information, announcements or newsletters from the clinic periodically.

SIGNATURE _____ DATE _____

FOR OFFICE USE ONLY: INSURANCE CARD(S) COPIED FINANCIAL POLICY SIGNED SIGNATURES VERIFIED CONTACTS NOTICE OF PRIVACY PRACTICES

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