Holmkvist MD. Dahl MD.
ACCREDITED DERMATOLOGY MEDICAL CLINIC INC.

PATIENT REGISTRATION RECORD

GENERAL INFORMATION

NAME:
LAST_____FIRST_____MIDDLE_____

DATE OF BIRTH_____AGE_____SOCIAL SECURITY NO_____

SEX: ☐ Female ☐ Male MARITAL STATUS (circle): Single Married Divorced Domestic Partner Widowed

PARENT/GUARDIAN NAME (for minors, individuals with guardians)_____
PRIMARY CARE PHYSICIAN _____
REFERRED BY_____

CONTACT INFORMATION (provide parent/guardian information for minors)
HOME STREET ADDRESS_____
CITY_____STATE_____ZIP_____

BILLING ADDRESS (if different than above) _____
CITY_____STATE_____ZIP_____
LAND LINE PHONE (_____) _____ CELL PHONE (_____) _____
WORK PHONE (_____) _____ EMAIL ADDRESS_____
EMERGENCY CONTACT(relative or friend not living with patient) _____
RELATIONSHIP_____PHONE (_____) _____

EMPLOYMENT INFORMATION ☐ Patient OR ☐ Parent/Guardian name_____
OCCUPATION_____EMPLOYER_____
WORK
ADDRESS_____
CITY_____STATE_____ZIP_____

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE CO_____ PHONE (_____) _____
ID/POLICY NO_____ GROUP NO_____
SUBSCRIBER/NAME OF INSURED_____RELATIONSHIP_____
SUBSCRIBER'S DATE OF BIRTH _____ SOCIAL SECURITY NO_____
SUBSCRIBER'S EMPLOYER _____

SECONDARY INSURANCE

INSURANCE CO_____ PHONE (_____) _____
ID/POLICY NO_____ GROUP NO_____
SUBSCRIBER/NAME OF INSURED_____RELATIONSHIP_____
SUBSCRIBER'S DATE OF BIRTH _____ SOCIAL SECURITY NO_____
SUBSCRIBER'S EMPLOYER _____

301 W. Bastanchury Road • Suite 245 • Fullerton, CA 92835 • P 714.525.3500 • F 714.525.3588

PATIENT REGISTRATION AGREEMENT

- TREATMENT CONSENT
- FINANCIAL AGREEMENT
- NOTIFICATION OF PRIVACY POLICY
- AUTHORIZATION TO RELEASE INFORMATION FOR MEDICAL INSURANCE CLAIMS AND PAYMENT OF BENEFITS TO PHYSICIAN.

I give the doctors and office staff permission for examination and treatment.

I understand I am financially responsible for all charges not paid by my insurance company including copayments, deductibles, and charges for cosmetic/non-covered services and that interest (1.5% per month) is assessed on all charges 30 or more days past due.

I have received a copy of the notice of privacy practices.

I hereby authorize the offices of Drs. Patrick Dahl & Kristina Holmkvist to release medical information relating to all medical insurance claims for benefits submitted on behalf of myself and/or my dependents. I authorize my insurance company to assign my benefits directly to Dr. Patrick Dahl or Kristina Holmkvist for services rendered. I authorize the use of this signature on all my insurance submissions.

SIGNATURE_____DATE_____

(Parent/Guardian signature required for minors)

MEDICARE CLAIM AUTHORIZATION (for patients with Medicare insurance)

Name of Medicare Beneficiary: _____

Medicare Number: _____

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Accredited Dermatology Medical Clinic for any services furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the CMS-1500 claim form is completed my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Medicare Beneficiary Signature: _____

Date: _____

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