SANDRA I.READ, MD, Dermatology
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Patient registration: Today' Date:___/_____/__ ____ Referred by_____

Name: _____ _____

Address_____

Date of birth_____/_____/_____ Sex: F/M Social Security # _____

Home Phone:_____ _____ Cell Phone__ _____Circle what number may we contact you?
Employer_____ Occupation _____
Marital Status ____Spouse/Parent_____ Telephone Spouse or Parent_____
Emergency Contact _____

********POLICY CONCERNING PAYMENT OF MEDICAL BILLS***
Whether or not your insurance company pays in full, a portion, or no portion of your medical bills is a matter between you and your insurance carrier. Unless other arrangements have been made, any unpaid balances are due within 30 days of treatment.
Payment is expected in form of cash, check or credit card.
Preferred method of payment - Cash_____ Check _____ other _____
I agree to promptly pay all charges when billed for medical services rendered and accept legal responsibility for any and all charges for the patient named above.
PLEASE SIGN HERE: _____ _____

BILLING AND INSURANCE INFORMATION
First Name_____Last name _____ _ Relationship to patient. ____

Home address_____

Primary INSURANCE COMPANY _____
ID or Policy #_____ Group code _____
Address _____ Date Effective _____
Subscribers Name _____Sex __ Soc Sec # _____
Date of birth _____
Relationship to patient _____

Secondary Insurance: Company Name _____
ID or Policy # _____ _ Group code_____
Address _____Date Effective _____
Subscriber Name _____Sex__ Relationship to patient___
PATIENT SIGNATURE_____
Date: _____
Account #:_____

Thank you