

Date:05/09/2005

Time:11:16:51

**Patient Registration**  
Boyle Family Dermatology



PATIENT'S AUTHORIZATION

I hereby authorize the physician to furnish information to insurance carriers concerning this illness / accident, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as valid as the original.

\_\_\_\_\_  
Signature of Subscriber or Beneficiary

\_\_\_\_\_  
Date

Patient.Acct#: \_\_\_\_\_

Patient: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: ( ) - \_\_\_\_\_

Date of Birth: \_\_\_\_\_

City,ST Zip: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_

Employer: \_\_\_\_\_ Sex: \_\_\_\_\_

Responsible: \_\_\_\_\_ Home Phone: ( ) - \_\_\_\_\_

Address: \_\_\_\_\_ Work Phone: ( ) - \_\_\_\_\_

Relationship to Patient:

Self  Parent  Other

City,ST Zip: \_\_\_\_\_

Ins1 Holder: \_\_\_\_\_

Patient to Cardholder:

Self  Child  Other  Spouse

Ins1 Co.: \_\_\_\_\_

Copay: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Ins2 Holder: \_\_\_\_\_

Patient to Cardholder:

Self  Child  Other  Spouse

Ins2 Co.: \_\_\_\_\_

Copay: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Refer Dr.: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Emergency: \_\_\_\_\_

Phone: \_\_\_\_\_

**Acknowledgment of Receipt of Notice of Privacy Practices**

Thank you for choosing Boyle Family Dermatology for your healthcare needs. We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign to acknowledge that you have been provided with a copy.

\_\_\_\_\_  
Name of Patient (Print)

\_\_\_\_\_  
Signature of Patient (or legal representative)

\_\_\_\_\_  
Date of Birth:

\_\_\_\_\_  
Date of Signature:

\_\_\_\_\_  
Signature of Staff