Chelsea Skin and Laser
Patient Registration

Last Name ______________________________ First Name ____________________ Date ______________

Address ____

City _________________________________ State ___________ Zip ______________

Sex M F Date of Birth ________________ SS # ________-______-________

Home Phone ___________________ Work ____________________ Cell ____________________

Occupation ______________________________ Email ______________________________________

May we contact you via email regarding:
Your Appointment, Products/Services, Events/Discounts, Billing Y N

Pharmacy Name ________________________ Address _____________________ Phone ________________

Who may we thank for referring you? ______________________________________

Primary Care Physician

Name _______________________________ Phone ______________________

Address ____

Primary Insurance Information (required)

Please present your insurance card and ID to the front desk staff.

Primary Insurance Carrier _______________________________________

Policy # _____________________________ Group # ____________________

Name of Insured ________________________________

Assignment and Release

I, the undersigned, have insurance coverage with the above stated carrier and assign all medical benefits to Chelsea Skin & Laser (Eidelman Dermatology, PLLC). I understand that I am financially responsible for all charges, in full or in part, not paid by my insurance. If uninsured at time of visit, I understand that I am financially responsible for all charges. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian ________________________________ Date _____________

HIPAA Privacy Practices Notification

I, the undersigned, have been issued the HIPAA Notice of Privacy Practices. I fully understand that Eidelman Dermatology, PLLC is required by law to maintain the privacy of my medical and health information. I acknowledge that the Practice will use and disclose my health information for the purposes of treating me, obtaining payment for services referred to me and conducting health care operations.

Signature of Insured/Guardian ________________________________ Date _____________