

# Clear Skin Dermatology

## Family Registration

For Office Use Only: Account # \_\_\_\_\_

**Patient Information - or - Parent/Legal Guardian (if patient is under 18 years of age)**

(Please print with black ink)

Last Name \_\_\_\_\_ Home Phone \_\_\_\_\_  
 First Name \_\_\_\_\_ Sex (M/F) \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Address \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Family Doctor \_\_\_\_\_ City \_\_\_\_\_ Phone # \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Email Address \_\_\_\_\_

**Employer Information:**

Employer Name \_\_\_\_\_  
 Employer Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

| In Case of an Emergency Call: |       |
|-------------------------------|-------|
| Name                          | _____ |
| Phone                         | _____ |

**Dependent Information:**

1) Dependent Name \_\_\_\_\_ Dependent Date of Birth \_\_\_\_\_ Gender: Male Female  
 2) Dependent Name \_\_\_\_\_ Dependent Date of Birth \_\_\_\_\_ Gender: Male Female

**Primary Care Physician:** \_\_\_\_\_ PCP Phone: \_\_\_\_\_

**Primary Insurance Information:**

**\*\*Insurance card must be present at time of appointment. Copayment will be due at appointment.**

Name of Insurance Policy \_\_\_\_\_ Policy # \_\_\_\_\_  
 Name of Policy Holder: \_\_\_\_\_ Group # \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_ Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Address (If different than patient) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Employer Name \_\_\_\_\_ Employer Phone # \_\_\_\_\_

**Secondary Insurance Information:**

Name of Insurance Policy \_\_\_\_\_ Policy # \_\_\_\_\_  
 Name of Policy Holder: \_\_\_\_\_ Group # \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Employer Name \_\_\_\_\_ Employer Phone # \_\_\_\_\_

**How did you hear about us?**

Doctor: (Whom can we thank?) \_\_\_\_\_ Phone Book \_\_\_\_\_ Insurance company \_\_\_\_\_  
 Friend: (Whom can we thank?) \_\_\_\_\_ Physician Finder (Delnor) \_\_\_\_\_ Home Mailer \_\_\_\_\_  
 Newspaper Ad: (what paper?) \_\_\_\_\_ Newspaper Article \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ASSIGNMENT OF BENEFITS**

**West Suburban Dermatology & Cosmetic Surgery / Clear Skin Dermatology  
Rany Jazayerli, M.D.  
Jennifer Cunningham, PA-C.**

**CONSENT FOR TREATMENT, RELEASE, ASSIGNMENTS AND FINANCIAL AGREEMENT:**

I hereby voluntarily consent to care encompassing routine diagnostic procedures and medical treatment authorized by Dr. Jazayerli. I authorize any holder of medical or other information about me to release any information needed to process my insurance claims and to permit a copy of this authorization to be used in place of the original.

I authorize payment of medical benefits to West Suburban Dermatology & Cosmetic Surgery / Clear Skin Dermatology. I absolutely and unconditionally guarantee payment in full for clinical services rendered to me by West Suburban Dermatology & Cosmetic Surgery / Clear Skin Dermatology. Please note that in the case of divorce; payment is expected from the parent/guardian who is with the patient. Parents/guardians are expected to work out payment arrangements with each other and not involve WSD/CSD in any disputes.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**MEDICARE PATIENTS ONLY:**

**STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO  
PROVIDER, PHYSICIANS, AND PATIENTS**

I request that payments of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in West Suburban Dermatology & Cosmetic Surgery / Clear Skin Dermatology, including my physician services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Medicare Number (HICN)

**MEDIGAP**

I request that payment of authorized MediGap benefits be made either to me or on my behalf to West Suburban Dermatology & Cosmetic Surgery / Clear Skin Dermatology for any services furnished to me by my physician. I authorize any holder of medical or other information about me to release to \_\_\_\_\_ (Name of Secondary) any information to determine these benefits or the benefits payable for related services.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**CLEAR SKIN DERMATOLOGY & COSMETIC SURGERY**  
**Request to Receive Confidential Communications of Protected Health Information**

As stated in our Notice of Privacy Practices, you may request that we communicate confidential health information to you by alternative means or in alternative locations. The Privacy Rule requires us to accommodate requests if reasonable. Please indicate your request regarding communication below and answer ALL the questions listed. If it does not apply, please mark the NA field.

Patient Name: \_\_\_\_\_ Today's Date; \_\_\_\_\_ Account# \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**APPOINTMENTS AND BILLING INFORMATION**

- Leave message on my home answering machine.  Yes  No  NA
- Leave message with persons at my home.  Yes  No  NA
- Call me on my cell phone.  Yes  No  NA
- Leave message on my cell phone voice mail.  Yes  No  NA
- Contact me at my work.  Yes  No  NA  
If yes, OK to leave a message?  Yes  No

**CONFIDENTIAL INFORMATION (including results, medical information)**

- Contact me at my home.  Yes  No  NA
- Leave message on my home answering machine.  Yes  No  NA
- Leave message with persons at my home.  Yes  No  NA
- Call me on my cell phone.  Yes  No  NA
- Leave message on my cell phone voice mail.  Yes  No  NA
- Contact me at my work.  Yes  No  NA  
If yes, OK to leave a message?  Yes  No

➤ Do you have a Medical Power of Attorney Assigned?  Yes  No **If YES, please provide us with a copy**

➤ Do you want a family member to have access to your personal health information (spouse, parent, child)? If so, please list their name and relationship to you.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

➤ Can we send sealed confidential information to your home address?  Yes  No

**If NO, list another address** \_\_\_\_\_

➤ Other requests for confidential communications: \_\_\_\_\_

\*\*\*\*\*

**Patient Receipt of Notice of Privacy Practices**  
**I have received the Notice of Privacy Practices from my physician**

\_\_\_\_\_  
Patient (if >18years old) or Parent **Signature**

\_\_\_\_\_  
Date