# PATIENT REGISTRATION FORM

One Scobee Circle, Plymouth, MA 02360 P 508.747.0711
75 Washington Street, Norwell, MA 02061 P 781.878.6495

SouthShoreSkinCenter.com

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**Patient Name:**______________________________________________

**Address:** ______________________ **City/State/Zip:** ______________________

**Home Phone:** ______________ **Work Phone:** ____________ **Cell Phone:** ______________

**Email:** ____________________________________

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**Date of Birth:** ____________ **Age:** ______ **Social Security Number:** ________________

**Marital Status:** ____________ **Language:** ______________ **Race:** ______________

**Primary Care Physician:** ________________ **Address:** ______________________

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**Emergency Contact Name:** ______________ **Relation:** ________ **Phone Number:** ____________

**Pharmacy Name:** ________________ **Pharmacy Location:** ________________

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## INSURANCE INFORMATION:

**Primary Insurance:** ________________

**Subscriber Name:** ________________

**Relation To Patient :** ________________

**Subscriber ID:** ________________

**Group Number:** ________________

**Secondary Insurance:** ________________

**Subscriber Name:** ________________

**Relation To Patient :** ________________

**Subscriber ID:** ________________

**Group Number:** ________________

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**MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR ANSWERING MACHINE OR VOICEMAIL:**

❑ Yes ❑ No If yes, check all that apply: ❑ Home ❑ Cell ❑ Work

**MAY WE CONTACT YOU WITH APPOINTMENT INFORMATION BY PHONE, E-MAIL OR TEXT:**

❑ Yes ❑ No If yes, check your preferred method of contact: ❑ Phone ❑ Email ❑ Text

**MAY WE E-MAIL YOU INFORMATION ABOUT NEW TREATMENTS, SERVICES OR PRODUCTS:** ❑ Yes ❑ No

**DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH FAMILY:**

❑ Yes ❑ No

Name:________________________Relationship:__________Phone: ____________

**DID YOU RECEIVE A COPY OF SOUTH SHORE SKIN CENTER'S OFFICE POLICIES:** ❑ Yes ❑ No

**DID YOU RECEIVE A COPY OF SOUTH SHORE SKIN CENTER'S NO-SHOW POLICY:** ❑ Yes ❑ No

**INSURANCE RELEASE AND ACKNOWLEDGEMENT OF FINANCIAL OBLIGATION:**

❑ I hereby authorize release of information requested by my insurance company to process claims for medical benefits and I ASSIGN BENEFITS OTHERWISE PAYABLE TO ME, to South Shore Skin Center for services provided. I certify that the information I furnish is true and correct. I understand that I am financially responsible for all charges to my account irrespective of my assignment of benefits. I also understand that balance more than sixty days overdue will be subject to a monthly finance charge of 1.5% per month and costs of collection.

**RECEIPT OF NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGMENT FORM:**

❑ I hereby acknowledge that on__________I was offered or received a copy of South Shore Skin Center's Notice of Privacy Practices, which sets forth the ways in which my personal health information may be used or disclosed by South Shore Skin Center, and outlines my rights with respect to such information.

**Date**__________ **Signature of Patient or Legal Guardian**____________________