GREENBRAE DERMATOLOGY – A MEDICAL CORPORATION

Registration Form for Minors and Dependent Adults

Patient's name: _____ Name you prefer to be called: _____
Mother's name: _____ Father's name: _____
Mother's employer: _____ Father's employer: _____
Mother's occupation: _____ Father's occupation: _____
Mother's address: _____ City: _____ State: ____ Zip: _____
Father's address: _____ City: _____ State: ____ Zip: _____
Check preferred phone: Is it okay to leave a detailed message on your phone? ☐YES ☐NO
☐ Cell: _____ ☐ Home: _____ ☐ Work: _____
Patient's DOB: _____ Age: _____ ☐ MALE ☐ FEMALE
Email: _____
Sign here if we have authorization to treat without parent present: **X**_____
Other family members seen in this office: _____
How did you find out about us? _____
Any outdoor hobbies/sports: _____
Do you use facial sunscreen? ___ rarely ___ intermittently ___ everyday ___ every 2 hours while in the sun
Chronic medical conditions (such as asthma, seasonal allergies, eczema): _____
_____
Medication allergies: _____
Medicines you take (including vitamins, herbal supplements): _____
_____

Primary Insurance	Insured's ID #	Secondary Insurance	Insured's ID #
Subscriber's name		Subscriber's name	
Subscriber's Address		Subscriber's Address	
City, State, Zip		City, State, Zip	
Insured's Policy/GRP#		Insured's Policy/GRP#	
Subscriber's DOB	Relationship to Patient (circle one) Self /Spouse/Child/Other:	Subscriber's DOB	Relationship to Patient (circle one) Self /Spouse/Child/Other:

Pediatrician/Primary MD: _____
Preferred Pharmacy: _____

OFFICE POLICY: Assignment of Benefits – Financial Agreement – I hereby give lifetime authorization for payment of insurance benefits to be made directly to Greenbrae Dermatology, A Medical Corporation. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and the reasonable attorney's fees. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Date: _____ Parent's Signature: _____