CAPITAL DISTRICT DERMATOLOGY PATIENT REGISTRATION FORM

MEDICAL INSURANCE INFORMATION

Primary Insurance:_____

Subscribers Name:_____

Subscribers Date of Birth:_____ Relationship to Subscriber:_____

Co-Pay:_____ Policy ID:_____ Group:_____

Secondary Insurance:_____-_____

Subscribers Name:_____

Subscribers Date of Birth:_____ Relationship to Subscriber:_____

Co-Pay:_____ Policy ID:_____ Group:_____

INSURANCE COVERAGE WAIVER

I understand that my eligibility for coverage by the insurance named in this document cannot be confirmed at this time. I wish to receive medical services from Capital District Dermatology. If it is determined that I am not eligible for coverage under this plan, I understand that I will be responsible for payment of all services provided.

INSURANCE BENEFITS/RELEASE MEDICAL INFORMATION

I authorize Capital District Dermatology to release information necessary medical or other information to persons employed or retained by or affiliated with the insurance company I have provided that may be required in order to process insurance claims/payments.

_____ _____

Signature of Patient/Guardian Date