Affiliated Dermatologists, Inc.
Edward A. Searle, M.D. Jill S. Mines, M.D.
3901 Las Posas Rd., Ste 108, Camarillo Ca, 93010
(P) 805-484-3331 (F) 805-987-2118

PATIENT REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Patient Name: ____
Last First M.I.

Preferred Name: ____________________ Birth Date: ___/___/___ Sex: ☐ M ☐ F

Street Address: ____

PO Box: ________ City: ____________________ ST: ______ ZIP Code: ________

Email Address: ____

Home Phone: ____________________ Cell Phone: ____________________

Primary Care Doctor: ____________________ Your Pharmacy: ____________________

Referred By: ☐Dr. ____________ ☐Insurance Plan ☐Hospital ☐Family ☐ Friend

INSURANCE INFORMATION

PRIMARY INSURANCE: ____

Subscriber's Name: ____________________ Subscriber's Date of Birth: ___/___/___

Group no.: ____________________ Policy no. (ID#): ____________________

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other:

SECONDARY INSURANCE (if applicable): ______________________________

Subscriber's Name: ____________________ Subscriber's Date of Birth: ___/___/___

Group no.: ____________________ Policy no. (ID#): ____________________

Patient's relationship to subscriber: ☐Self ☐Spouse ☐Child ☐Other:

IN CASE OF EMERGENCY

Name of local relative or friend: ____________________ Home/Cell phone: ____________

Relationship: ____________________

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Affiliated Dermatologists Inc., or insurance company to release any information required to process my claims.

______________________________ ______________________________

Signature (Patient / Legal Guardian) Date

Affiliated Dermatologists, Inc.

Edward A. Searle, M.D. Jill S. Mines, M.D.

Authorization to Pay Medical Benefits to Physicians Patient Demographic Information

I hereby request payment of Medicare and/or commercial insurance medical benefits to be paid directly to Affiliated Dermatologists, Inc. and/or Dr. Mill Mines, M.D., Dr. Edward Searle, M.D. I authorize the release to Medicare and/or my commercial insurance carrier any medical information necessary to process claims for medical services. I understand that payment of my account is ultimately my responsibility. I understand that if my insurance company does respond to a properly sent claim within 90 days, it is my obligation to pay the physician for services. I understand tat I will be financially responsible for non-covered services.

I declare that the information listed on my Patient Registration form is correct and current. I understand that is my responsibility to inform the office of any changes in my address, phone numbers(s), insurance information, and emergency contact information.

I am aware that I may be required to fill out a new Patient Registration form if requested.

Signature (Patient / Legal Guardian) Date

Signature (Patient / Legal Guardian) Date

Signature (Patient / Legal Guardian) Date

Signature (Patient / Legal Guardian) Date

Signature (Patient / Legal Guardian) Date

Signature (Patient / Legal Guardian) Date

Patient Name DOB Acct#