Duke Lightner Dermatology, CPDC
Patient Registration Form

Patient Label Here

Full Legal Name:_____ Today's Date____/____/____

Address:_____ Name you prefer to be called:_____

_____ Sex: [ ] M [ ] F [ ] Other Date of Birth:____/____/____

City, State, Zip:_____ Marital Status: [ ]Married [ ]Single [ ]Divorced [ ] Widowed
[ ]Partner [ ]Other_____

Home Phone:_____ Social Security#:_____

Work Phone:_____ Primary Physician:_____

Cell Phone:_____ Other_____ Referring Physician:_____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Other _____

Ethnicity: ☐ I am Hispanic/Latino ☐ I am not Hispanic/Latino ☐ Unknown/Decline to Answer

Preferred language: ☐ English ☐ Spanish ☐ Other _____

PATIENT EMPLOYMENT: [ ]Employed [ ]Retired [ ]Student [ ]Disabled [ ]Other_____

Employer/School: _____
Name Address Phone

EMERGENCY CONTACT: In case of emergency, whom should we notify?

_____
Name Phone Relationship

GUARANTOR/RESPONSIBLE PARTY (Who is responsible for the patient payment on this account?)
[ ] Same as Patient (skip to next section)

Name:_____ Relationship to Patient: _____

Address:_____ City, State, Zip:_____

Date of Birth:____/____/____ Employer: _____

Home Phone: _____ Work Phone: _____

Do you have a Duke MyChart account? [ ] yes [ ] no
If not, we can help you sign up. Please provide your email address: _____

May we leave personal medical information on your answering machine/voice mail? [ ] yes [ ] no

How would you like us to contact you for appointment reminders?
[ ] Home# [ ] Work# [ ] Cell# [ ] email [ ]MyChart

(continue on other side)

INSURANCE INFORMATION (please fill in all blanks, write none if it doesn't apply)

PRIMARY INSURANCE: [ ] Same as Patient (skip to next section) [ ] Same as Guarantor (skip to next section) [ ] Other

Name of Insurance Company: _____

Name of Policy Holder (Insured): _____ Relationship to Patient: _____

Insured's Date of Birth: ____/____/____ Home Phone: _____

Insured's Address if different from above: _____
Street City State Zip

Employer: _____
Name Address Phone

SECONDARY INSURANCE: [ ] None [ ] Same as Patient [ ] Same as Guarantor [ ] Other

Name of Insurance Company: _____

Name of Policy Holder (Insured): _____ Relationship to Patient: _____

Insured's Date of Birth: ____/____/____ Home Phone: _____

Insured's Address if different from above: _____
Street City State Zip

Employer: _____
Name Address Phone

Please present insurance card(s) and photo ID to the receptionist so copies may be made.

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. We accept assignment on many insurance companies upon verification of benefits. If we are unable to verify coverage at the time of your visit, we reserve the right to request payment in full. Once coverage is verified, you are required to pay your deductible, co-insurance and/or copay. PAYMENT IS EXPECTED FROM YOU, **AT THE TIME OF SERVICE**, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT CASH, CHECK AND MOST MAJOR CREDIT CARDS FOR YOUR CONVENIENCE.

YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER. Because of the complexities of insurance filing, we offer this service as a courtesy to our patients. We are happy to assist you in any way to assure you receive your benefits; however you are ultimately responsible for timely payment of your bill. You will be billed for any unexpected uncovered services after insurance responds.

Uninsured patients or those filing their own insurance are expected to pay in full at the time services are provided. Again, we accept cash, check, and most major credit cards. We do not wish to deny services to patients who are truly unable to pay. If you are having a financial crisis, you must make payment arrangements with our Financial Care Counselor before the doctor treats you.

Duke Lightner Dermatology charges a **no show fee** of $56.00 for any appointment that in not kept or canceled in advance. If you have extenuating circumstances that cause you to miss an appointment, please contact our office as soon as possible after the appointment.

Your signature below indicates you understand and accept these policies.

_____ _____
Patient/Responsible Party Signature Date