Dermatology ASSOCIATES of Northern Kentucky

MARK J. ZALLA, M.D. SUSAN J. BUSHELMAN, M.D. MOLLY G. EISNER, M.D. CLAYTON D. CONNER, M.D. JOHN DEIS, M.D.
ELLIOTT H. CAMPBELL, M.D. MAE L. DINN, MPAS, PA-C KRISTIN D. KENNEDY, APRN MARIE N. SARTORI, APRN
KATHRYN WEST-PFINGSTON, APRN

Registration Form - Patient Information (PLEASE PRINT)

Last Name:	First Name:	Middle Name:	Prefix:	
Address:	City/State:	Zip:	Nickname:	
DOB: / Age	S.S. #	PREFERRED NUMBER ❑ Home Phone:		
Employer Name:	Employment Status: ☐ Full time ☐ Retired ☐ Part time ☐ Not Employed	PREFERRED NUMBER ❑ Cell Phone:		
Referring Physician:	Marital Status: ☐ M ☐ S ☐ D ☐ W	_____Check here if we can leave a detailed message		
Pharmacy Name/Location:	Pharmacy Phone Number:	Primary Care Physician:		
Email:	Language: ☐ English ☐ Other_____	Race:	PCP Phone#:	

☐ **Same as patient** **Guarantor Information (Person responsible for all financial obligations)**

Last Name:	First Name:	Birthdate:	
Address:	S.S. #	Relationship to patient:	
Home Phone:	Cell Phone:	Email Address::	

Insurance Information

Primary Insurance Information

Insurance Company:	Group# / Plan ID:	Member Number:	
Subscriber Employer Name:	Patient Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other	Sex: ☐ M ☐ F	
Subscriber Name:	Subscriber DOB:	Copay:	

Secondary Insurance Information

Insurance Company:	Group# / Plan ID:	Member Number:	
Subscriber Employer Name:	Patient Relationship to Insured: ☐ Self ☐ Child ☐ Spouse ☐ Other	Sex: ☐ M ☐ F	
Subscriber Name:	Subscriber DOB:	Copay:	

The undersigned patient or guardian certifies that the above facts are correct and agrees as follows:

1. Authority is granted to Dermatology Associates of Northern Kentucky to render needed treatment and/or tests for the above named patient.
2. I authorize Dermatology Associates of Northern Kentucky to release any information required for payment of claims.
3. I authorize my insurance or Medicare benefits to be paid directly to Dermatology Associates of Northern Kentucky, realizing I am responsible to pay noncovered and unauthorized service.
4. If you are unable to keep your appointment, 24 business hour cancellation notice is required. If you miss your appointment or cancel without notifying our office at least 24 business hours prior, you will be charged $50.00 for each missed office appointment, and $100.00 per site for each missed surgery appointment. This charge is not billable to your insurance. **If you are more than 30 minutes late for an appointment, you may need to reschedule.**
5. We will need to make copies of your photo ID and Insurance Card(s)
6. Return Check Fee, you are charged $35.00 if your check is returned from the bank.

_____ _____ _____
The above information is correct / Patient or Guardian Signature Date Staff Initials