4201-200 Lake Boone Trail
Raleigh, NC 27607
(O) 919/ 782-2152
(F) 919/ 782-7929

SOUTHERN DERMATOLOGY
SKIN CANCER CENTER
SKIN RENEWAL CENTER

Gregory J. Wilmoth, MD
Eric D. Challgren, MD
Margaret B. Boyse, MD
Laura D. Briley, MD
Tracey S. Cloninger, PA-C

Patient Registration Form

Today's Date: _____ **Account#:**_____

Last Name:_____ **M.I**_____ **First Name:** _____

Date of Birth_____/_____/_____ **Sex: Male___Female___Other___ Language: English___Spanish ___**

Home Address: _____ **Apt/Unit**: _____

City, State, Zip Code: _____

Home Phone:_____**Mobile Phone**:_____**Work Phone**: _____

Preferred Phone (please circle) Home / Mobile / Work **Email Address:** _____

By adding your email you're giving us permission to add you to our email list

Referring Provider:_____**PCP:** _____

Primary Insurance Company:_____ **Policy Holder DOB:** _____ **Policy Holder Name**_____

Secondary Insurance Company:_____**Policy Holder DOB:** _____ **Policy Holder Name**_____

I am giving permission to contact me by: phone email text Signature_____

Race: ☐ White ☐ American Indian/Alaskan Native ☐ Black or African American ☐ Hawaiian / Pacific Islander ☐ Asian ☐ Unspecified ☐ Declined

Ethnic Group: ☐ Hispanic/Latino ☐ Non-Hispanic Latino ☐ Unknown/Refused

Financial Responsibility

- I agree to promptly pay for any service(s) provided to me not covered by my insurance policy.
- I agree to pay all copayments, coinsurance, and deductibles, and for cosmetic services, at the time service is rendered.
- I agree to provide at least 1 business day notice to cancel/reschedule an appointment. Failure to do so may result in administrative fees of $25 for office visits, $100 for surgical visits.
- I understand it is my responsibility to verify my insurance company benefits coverage and to obtain any necessary authorizations/referrals/approvals from my insurance company and/or my primary care physician.

_____ _____

Signature of Patient / Responsible Party or Parent / Legal Guardian (**If patient is a minor**) Date:

Consent to Treat

I understand my provider & I will discuss and agree on an appropriate treatment plan and I consent to participate in that plan as determined. If patient is a minor presenting for evaluation and/or treatment without an accompanying parent/legal guardian, I hereby give my permission to evaluate and treat the minor patient.

_____ _____

Signature of Patient / Responsible Party or Parent / Legal Guardian (If patient is a minor) Date:

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Patient Information Form (Protected Health Information)

Last Name:_____ First Name: _____

DOB:_____ Account#: _____

Notice of Privacy Practices (NPP) Acknowledgement

I acknowledge that a copy of the NPP has been made available to me. I understand the NPP is subject to change at any time. I may obtain a revised copy of the NPP upon request.

_____ _____

Signature of Patient/Responsible Party or Parent/Legal Guardian (if patient is a minor) **Date:**

Southern Dermatology Only

Patient declined to sign after NPP was made available. Staff Signature/Witness:_____ Date:_____

Authorization to Access Personal Health Information

I authorize the following family members, friends or other individuals access to my personal health information. Personal hea lth information (PHI), also referred to as protected health information, generally refers to demographic information, medical history, test and laboratory results, insurance information and other data that is collected by a health care professional to identify an individual and determine appropriate care. Please indicate the individuals and type of PHI you are authorizing the office to release when necessary.

Name:_____ Relationship:_____ ☐ Medical ☐ Financial ☐ Other

Name:_____ Relationship:_____ ☐ Medical ☐ Financial ☐ Other

Name:_____ Relationship:_____ ☐ Medical ☐ Financial ☐ Other

_____ _____

Patient Signature **Date**