CLEARVIEW
DERMATOLOGY
The Clear Path to Healthy Skin

New Patient Registration

Patient Name *

First Name Last Name

Gender *

Male

Female

Date Of Birth *

Month Day Year

Guarantor Name If Patient is Under 18 (Person responsible for the bill).

First Name Last Name

Address *

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code

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Best Contact Phone Number *

Area Code Phone Number

Phone Type *

Cell

Home

Work

Ok To Leave Detailed Messages *

Alternate Phone Number

Area Code Phone Number

Alternate Phone Type

Cell

Home

Work

Preferred e-mail for appointment reminders (type none if none). *

example@example.com

Health Insurance *

Blue Cross Blue Shield

Tufts

Medicare

Medicaid

Cigna

Aetna

Harvard Pilgrim

United Healthcare

Tricare

Self Pay ($100 downpayment required)

Health Insurance policy/member Id# as it appears on your insurance card; *

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Subscriber/Policy Holder Name *

First Name Last Name

Relationship to Subscriber *

Group Number from insurance card if applicable.

Secondary Health Insurance (Complete if you have a supplemental insurance) *

- Blue Cross Blue Shield
- Tufts
- Medicare
- Medicaid
- Cigna
- Aetna
- Harvard Pilgrim
- United Healthcare
- Tricare
- Self Pay ($100 downpayment required)
- None

Secondary Subscriber/Policy Holder Name

First Name Last Name

I understand that if I do not have insurance I will be self-pay, and $100 down payment will be required at the time of service. I understand that I will be balance billed any additional charges.

Signature

Clearview Dermatology bills all insurance companies as a courtesy to our patients. I understand it is ultimately the parent/guardian responsiblity to ensure all services are paid in full.

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Signature

I authorize Clearview Dermatology, LLC (aka Leominster Dermatology, LLP) to release my medical diagnosis to my primary care physician, other health care facilitiy(s), or specialst(s) as necessary to coordinate my care.

Signature

I authorize any holder of medical or other inforation about me to release to the Social Security Administration/Health Care Financing Administration, its intermediaries/carriers, and/or any other health insurance carrier any information needed for this or related health insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of insurance benefits be made directly to the provider who accepts assignment.

Signature

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