

**Levy Dermatology, P.C.**  
**1920 Kirby Parkway, Suite 204**  
**Germantown, TN 38138 (901) 624-3333**

Account # \_\_\_\_\_

**Patient Registration**

Please print and answer all questions in full

Date: \_\_\_\_\_

**Patient Information** (please complete using your name as listed on your insurance card)

**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ May we leave voice mails? Yes No (circle)

**Email Address:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Marital Status:** Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widow \_\_\_\_\_ **Sex:** M \_\_\_\_\_ F \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

How did you hear about us: Dr Family/Friend Internet Yellow pages White pages Other \_\_\_\_\_

**Insurance Responsibility** Is the Person Responsible for the insurance the patient? No \_\_\_\_\_ Yes \_\_\_\_\_  
(if yes, continue to Insurance Information. If no, please answer the following questions.)

**First Name:** \_\_\_\_\_ **Middle Initial:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Sex:** M \_\_\_\_\_ F \_\_\_\_\_ **Occupation:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Insurance Information**

All Patients must provide a copy of their insurance card at the time of their visits. In-Network Lab \_\_\_\_\_

**Primary Insurance:** \_\_\_\_\_ **Name of Insured:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Insured's DOB:** \_\_\_\_\_ **Policy #** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ **Name of Insured:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Insured's DOB:** \_\_\_\_\_ **Policy #** \_\_\_\_\_ **Group #** \_\_\_\_\_

**Referring Physician Information**

**Referring Physician:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Primary Care:** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**Emergency Contact Information**

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Office Policy**

*Please remember that insurance is considered a method of reimbursing the patient for fees paid to Levy Dermatology, P.C. and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges. In order to control the cost of billings, we request that our office visit charges be paid at the conclusion of each visit. I am aware that my insurance copay is to be paid each date of service. If my insurance plan requires an authorization for this visit and any follow up visits, it is my responsibility to ensure that the referral is current and on file with Levy Dermatology, P.C. **IT IS MY RESPONSIBILITY TO PAY ANY DEDUCTIBLE AMOUNT, CO-INSURANCE, OR OTHER BALANCES NOT PAID BY MY INSURANCE COMPANY.** I am aware that if Levy Dermatology, P.C. does not participate with my plan or if I have no insurance, payment in full must be made on the date of service.*

***Authorization to Assign Benefits** - I hereby authorize insurance payments to be made directly to Levy Dermatology, P.C. for any services rendered. I agree to pay any balance specified by my insurance plan as my responsibility which may include deductible, co-insurance and non-covered services. I understand that I am responsible for any amount not covered by my insurance for medical services rendered to myself and for my dependents.*

***Authorization to Release Information** - I hereby authorize Levy Dermatology, P.C. to release any information acquired during my examination or treatment to third-party payors for payment of the charges.*

→ Signature: \_\_\_\_\_

Date: \_\_\_\_\_