JON R. JACOBS, M.D.
COSMETIC & SURGICAL DERMATOLOGY

PATIENT REGISTRATION FORM

NAME: _____ _____
First name Last name PHARMACY NAME AND LOCATION

Mailing ADDRESS: _____city_____zip_____

CELLULAR#:_____Email:_____

AGE: _____ DOB:_____ Height_____ Weight_____M_____F_____Race:_____

SOCIAL SEC. #: _____

OCCUPATION: _____ BUSINESS PHONE #: _____

EMPLOYER: _____

EMERGENCY CONTACT PHONE # & ADDRESS: _____

SPOUSE / PARENT: _____ADDRESS: _____

REFERRED BY: _____ FAMILY PHYSICIAN: _____

PERSON RESPONSIBLE FOR PAYMENT IF OTHER THAN SELF: _____

ADDRESS: _____ PHONE: _____

INSURANCE INFORMATION

(Please supply Insurance cards for copying)

PRIMARY INSURANCE CARRIER: _____
ADDRESS: _____
PRIMARY POLICY HOLDER:_____ DOB:_____
POL. #: _____ GROUP #: _____
Secondary Insurance Carrier_____policy #_____

PAYMENTS FOR SERVICES ARE TO BE MADE AT THE TIME SERVICES ARE RENDERED.

LIFETIME SIGNATURE AUTHORIZATION: I authorize the physicians and assistants of Jon R. Jacobs, M.D. to administer medical care as deemed necessary. I authorize the release of any medical information requested by my insurance carrier in order to process insurance claims.
I understand I am personally responsible for all fees (including deductibles and co-payments) incurred for services rendered to me or my child.

SIGNATURE: _____ DATE: _____
Parent or Guardian to sign if patient is a minor

MEDICARE PATIENTS: I request payment of authorized Medicare benefits be made either to me or on my behalf to Dr Jon R Jacobs, for any services furnished me by that physician/clinic. I understand that I am fully responsible for any yearly deductible and/or coinsurance balance due after Medicare. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

SIGNATURE: _____ DATE: _____
Parent or Guardian to sign if patient is a minor

MANAGED CARE AND PREFERRED PROVIDER ORGANIZATION (HMO/PPO) PATIENTS: I understand that I am responsible for all deductibles and co-payments at the time of service. I further understand that should payment be denied due to "PRE EXISITING ILLNESS", NON-COVERED OR TERMINATION OF COVERAGE, I will be responsible for payment of such fees within 10 days of such notification.

SIGNATURE: _____ DATE: _____
Parent or Guardian to sign if patient is a minor