John Q. Binhlam, M.D., P.C.
Advanced Skin & Laser Center (ASLC)

PATIENT REGISTRATION FORM

Patient Name: Last_____ First: _____ MI_____ □ Married □ Single

Date of Birth: ____/____/_____ Age: _____ Sex: □ Male □ Female Social Security#_____

Address: _____City_____ State _____Zip Code _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell: (_____) _____

Preferred Contact Method: □ Cell phone □ Home phone □ Work phone

Email: _____

Would you like to receive emails regarding specials and events? □ Yes □ No

Military: □ Yes □ No if yes, are you retired? □ Yes □ No

Employer: _____ Occupation: _____

Were you referred to our office, if so please tell us who referred you? _____

GUARDIAN OR PARENT INFORMATION

Name: _____SS#_____DOB ____/_____/_____

Address: _____ City: _____State:_____ Zip Code:_____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell: (_____) _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Employer _____

Policy Holder's Name: _____Date of Birth: ____/____/____SS#_____

Secondary Insurance Carrier: _____ Employer: _____

Policy Holder's Name: _____ Date of Birth: ____/____/_____ SS# _____

Please Present All Insurance Cards and Photo ID to the Receptionist

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Phone :(_____) _____

Relationship to Patient: _____

Signature of Patient or Parent/Guardian:_____Date:_____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize John Q. Binhlam, M.D., P.C., Advanced Skin & Laser Center (ASLC), and/or Advanced Health Partners, to provide information to insurance carriers concerning my medical care and I hereby irrevocably assign to the doctor all payments for all the medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as the original.

Signature of Patient/Guardian_____ Date_____/_____/_____

PHOTO CONSENT

I give consent for medical photographs to be made of my child or me (or for person whom I am legal guardian). I understand that the photos will become a part of my medical record and will be used for medical record purposes only.

MEDICARE PATIENTS ONLY

I authorize medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier needed for this or a related Medicare plan. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to either myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Are you covered by any other insurance that makes Medicare Secondary? □ Yes □ No

If Medicare is your secondary insurance, Please circle the type of coverage you have:

1. Working Aged/Spouse Group Plan
2. ESRD
3. No Fault/Auto Primary
4. Workers' Compensation
5. Public Health Service/Other Federal Agency
6. Veterans Administration
7. Disabled
8. Beneficiary Under Age 65
9. Other Liability Insurance is Primary
10. Black Lung

Do you or your spouse work in a company which has more than 20 employees and have insurance coverage through that job? YES____ NO ____

Signature of Patient/Guardian _____ *Date* ____/_____/_____

MEDIGAP

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file: I request authorized MEDIGAP benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient/Guardian _____ Date_____/_____/_____

Relationship to Patient _____