Dermatology Associates of the South Bay (DASB)
Amber A. Kyle, M.D / Krishna Patel PA-C
20911 Earl Street Suite 310 -- Torrance, CA 90503 -- (310) 370-9970

PATIENT REGISTRATION / FACE SHEET

Date: _____

Last Name: _____ First Name: _____ M.I.: _____ Sex: M / F

Birth Date: _____/_____/_____ Age: _____ Last 4 digits of Social: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____*(to announce special events or promotional offers only)*

Phone**:** Home: _____ Cell: _____ Work: _____

Which is the **BEST** number to reach you during the day: **HOME** **CELL** **WORK** ***- Please Circle***

Occupation: _____ Employer: _____

EMERGENCY CONTACT: Name of friend or relative
(Preferably not living with you) _____

Emergency Number: _____

DO WE HAVE PERMISSION TO: (Please Circle)

Leave a message on your voicemail?	Yes	No	
Leave a message on your cell phone?	Yes	No	
Email (Non-encrypted or secure)	Yes	No	_____
Leave a message at work?	Yes	No	
Discuss your condition with anyone?	Yes	No	If yes, whom?_____

HOW DID YOU HEAR ABOUT US? Referral? _____

INSURANCE INFORMATION

Subscribers Name: _____ Subscribers Birthdate:_____/_____/_____

Relationship to Subscriber (Circle): Self / Spouse / Child / Other

Are you covered under an Employer or Union Policy? _____

Primary Insurance Policy**:** **Secondary** Insurance Policy**:**

Policy Number: Policy Number:

FINANCIAL POLICY:
If DASB is not a provider, I understand I will pay at the end of my visit. Medical necessity is up to the determination of my insurance provider. I authorize my insurance benefits to be paid directly to the practice, DASB. I understand this is a PPO contracted office and I agree that I am financially responsible for the services provided that is not covered under my insurance. Patient financial responsibility includes: all insurance deductibles, co-pays, all services provided for patients without insurance, or patients with HMO plans or non-contracted insurance. I also authorize DASB or my insurance company to release any information required to process any claims. Blood work and/or Biopsies which are referred to an outside facility, such as pathology, laboratory, or other diagnostic tests may be billed separately and will be in addition to the office visit charges.
I also understand that should my insurance company send payment to me, I will forward the payment to DASB w/in 48 hours. I agree that if I fail to send the payment to DASB, I will be responsible for any cost incurred by the office to retrieve their monies. (more information found on website, www.SouthBaySkinDoctor.com)

Office Policy on outstanding balances: Upon an office visit, if I have an outstanding balance totaling $75 or more (and the balance is 4 months or older), I am responsible to pay the balance at the time of my visit. If I cannot pay the entire balance, I will be considered a “cash” patient and will be responsible to pay cash/credit at the time of the office visit (I can submit my Superbill to insurance to seek reimbursement).

I agree to this financial policy and I have read and will receive a copy of this document if so desired.

Patient / Guardian Signature: _____ Date: _____/_____/_____