



3100 Duraleigh Road; Suite 201 • Raleigh, NC 27612 • Phone: (919) 390-0200 Fax: (919) 390-0219

Patient Registration Form

Name: \_\_\_\_\_ Title: Mr. Mrs. Ms. Miss Dr.  
First Middle Last

Mailing / Billing Address: \_\_\_\_\_  
Street # Street Name Apt #  
\_\_\_\_\_  
City State Zip Code

Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Alternate Phone: (\_\_\_\_) \_\_\_\_\_ work cell

Male  Female Employer's Name: \_\_\_\_\_ If Student: Full Time Part time

How did you hear about the Raleigh Skin Surgery Center? \_\_\_\_\_

**Our financial policy:** Payment is expected from you, at the time of service, for "your part" of the charges for services covered by insurance. Insurance coverage will be pre-verified and you will be responsible for any unmet deductible, coinsurance, and/or copayments. Cosmetic patients must pay in full at the time of service. We accept cash, personal checks, VISA and Mastercard. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes Raleigh Skin Surgery Center, PLLC to release such medical information necessary to your primary care or referring physician, to consultants if needed, and to the insurance company(s) listed below in order to process your insurance claim (if any). You herein authorize payment of medical benefits to Raleigh Skin Surgery Center, PLLC when an assigned claim is filed to the following insurance company(s):

**Primary Insurance**  
**Primary Insurance Company:** \_\_\_\_\_  
**Subscriber/Member ID#:** \_\_\_\_\_ **Group #:** \_\_\_\_\_  
**If different than yourself:** Name of policy holder: \_\_\_\_\_  
Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Your Relationship to policy owner:  Spouse  Child  Other

**Secondary Insurance**  
**Secondary Insurance Company:** \_\_\_\_\_  
**Subscriber/Member ID#:** \_\_\_\_\_ **Group #:** \_\_\_\_\_  
**If different than yourself:** Name of policy holder: \_\_\_\_\_  
Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Your Relationship to policy owner:  Spouse  Child  Other

Print and sign your form. Be sure to bring it with you to your appointment.

\*\*Please be sure to sign below in order to allow us to file your claim to the insurance(s) listed above.\*\*

✪ Signature of Patient or Legal Guardian ✪

Date