

# Patient Registration Form

Aurora Clinic /ND Center for Dermatology  
1451, 44<sup>th</sup> Ave. South, Suite 121 D, Grand Forks, ND 58201  
Phone 701-732-2700 or 1-888-732-2740 Fax 701-732-2701

Name: \_\_\_\_\_  
First Middle Last

\_\_\_\_ Married \_\_\_\_ Single Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Spouse Name: \_\_\_\_\_ Spouse's Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Address: \_\_\_\_\_  
Street Street Name Apt.# PO Box (if any)

\_\_\_\_ City State Zip

Phone: \_\_\_\_\_ (we will use this number to remind you of upcoming appointments)

Work Phone: \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email address \_\_\_\_\_  
(Your e-mail will only be used if your provider is unable to contact you by phone. Your e-mail won't be used for solicitation.)

Social Security Number: \_\_\_\_\_ Sex:  M  F

Who Referred You? \_\_\_\_\_ Primary Dr. ? \_\_\_\_\_

Employer: \_\_\_\_\_  
Name Address

If student:  Full Time  Part Time Name of School: \_\_\_\_\_

Where should statements of your account be sent if different from above?

\_\_\_\_\_  
Name: Address Apt.# City State Zip

Name of Insurance: (s) \_\_\_\_\_ Policy # (s) \_\_\_\_\_

Policy Owner if other than Patient \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Relationship To Policy Owner :  Spouse  Self  Child  Other

Do we have your permission to:

Leave a message on your answering machine at home?

Yes  No

Leave a message at your place of employment?

Yes  No

If an emergency if we can not get a hold of you who can we call?

Yes  No

If yes, whom: \_\_\_\_\_

Relationship \_\_\_\_\_

Is there any person other than yourself that we may discuss your medical care with  Yes  No

If yes, whom: \_\_\_\_\_

Relationship \_\_\_\_\_

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. I AGREE TO PAY ALL BILLS UPON RECEIPT OF STATEMENT OR AS EXPRESSLY AGREED. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date