Rockoff Dermatology Center
For Dermatology, Laser & Plastic Surgery
1101 Beacon Street, Brookline, MA 02446
28 Andover Street, Andover, MA 01810

Patient Registration Form

PATIENT INFORMATION *(please print)*

First Name______________________________ Middle Initial _________ Last Name_______________________________________

Date of Birth _______________________________ Social Sec. # _____________________________________Sex ❑ M ❑ F

Home Address ____ City______________________________________

State ________________________ Zip Code__________________ E-mail Address _______________________________________

Home Phone ____________________________________ Cell Phone ____

Occupation ___________________________ Employer ________________________________ Work Phone ____________________

Primary Care Physician____Phone #____

Referring Physician ____Phone #____

Responsible Party (if applicable)_____________________________ Phone # ____________________

Relationship ____

INSURANCE INFORMATION

Primary Insurance _____________________________________ Policy I.D. ____________________ Group # ____________________

Insurance Address ____ Co-pay amount ____________________

Subscriber Name ____ DOB ____________________ SS# ____________________

Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ ____________________

Secondary Insurance __________________________________ Policy I.D. ____________________ Group # ____________________

Insurance Address ____ Co-pay amount ____________________

Subscriber Name ____ DOB ____________________ SS# ____________________

Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child ❑ ____________________

PHARMACY INFORMATION

Pharmacy Name ____ Phone Number______________________________

Address____City _________________________ State __________________ Zip ___________

MEDICAL INFORMATION AND PAYMENT AUTHORIZATION

I hereby authorize medical treatment from Alan S. Rockoff, M.D. I authorize any holder of medical information about me to release to the Health Care Financial Administration and its agents, or other insurer, any information needed to determine these benefits payable for related services.

Date: ____ Signature:____

All professional services rendered are the responsibility of the patient. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn this service over to collection for non-payment after 90 days, then the patient is responsible for the bill, the interest, and collection. I also acknowledge that if I do not have a referral, that I am responsible for payment.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER:
I hereby authorize payment directly to the undersigned Provider for my charges.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize the undersigned Provider to release any information acquired in the course of my examination or treatment to my insurance company in writing or by fax.

Date: ____ Signature:____

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