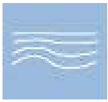
JENNIFER W. PENNOYER, M.D.
Medical & Surgical Dermatology
Laser & Cosmetic Skin Care

PATIENT REGISTRATION FORM

Patient Name (LAST, FIRST, MIDDLE INITIAL)		Email Address Can we email you? YES NO	
Address		Pharmacy name and address	
City		State	Zip Code
Home Phone	Cell Phone	Race	Marital Status
Date of Birth	Birth Sex	Sexual Orientation	Gender Identity
Employer		Primary Care Physician Name & address	
Emergency Contact Name/Phone #			Relationship
Insurance Policy Holder's Name		Relationship to insured	Policy Holders Date of Birth

INSURANCE AUTHORIZATION AND ASSIGNMENT

I request that payment of authorized Medicare/Other Insurance Company benefits be made to either me or on my behalf to Jennifer W. Pennoyer, M.D. for any services furnished me by that party who accepts assignment/physician. Regulations pertaining to Medicare assignment of benefits apply. I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim/other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying in my treatment.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

"I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the Privacy Officer. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified, or changed in any way."

☐ Patient Refused to Sign ☐ Patient was unable to sign because

Signature: ______________________________ Date: ______________