

**Jack A. Dekkinga MD PC**  
**Dermatology and Mohs Micrographic Surgery**  
*Giving Care that is More than Skin Deep*

Jack A. Dekkinga, MD      Gina C. Ang, MD  
 Ron W. Reusch, PA-C      Molly Duiven, PA-C      Amber E. Kintigh, PA-C      Kurt J. VanderVeen, PA-C

**Patient Registration Form**

**PLEASE PRINT**, for scanning purposes we request that you use only black ink. Please fill out and bring with you to your appointment.

**Patient Information**

Social Security Number: \_\_\_\_\_ Home Telephone ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
 Last Name: \_\_\_\_\_ Title: \_\_\_\_\_ Work Telephone ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
 First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Jr Sr Cell Telephone ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
 Address: \_\_\_\_\_ Gender:  Male       Female  
 \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Zip Code \_\_\_\_\_ May we e-mail personal information to you?  Yes  No  
 Marital Status: \_\_\_\_\_ Student Status:  None  Part-Time  Full-Time

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 Were you referred to our practice by another Dr?  Yes  No  
 If so, name: \_\_\_\_\_ Phone # ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
 Is this referring physician also your Primary Care Dr?  Yes  No  
 If not, who is your PCP? \_\_\_\_\_ Phone # ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

\*\*For your protection, and in compliance with Federal Regulatory Requirements to safeguard against identity theft you will be required to provide us with a valid photo ID with your current address and your insurance card every visit. We will scan this into our system in order to verify your identity in respect to any requests for your medical information and submitting of information to your insurance carrier for payment.

**Account Information**

Is the patient listed above over the age of 18?  Yes  No  
 If yes, the patient is legally responsibly for all financial obligations to this office.  
 If No, who is financially responsible for this account?

Last Name: \_\_\_\_\_ Home Telephone ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
 First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Jr Sr Work Telephone ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
 Address: \_\_\_\_\_ Cell Telephone ( \_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
 \_\_\_\_\_ Gender:  Male       Female  
 City \_\_\_\_\_ State \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Zip Code \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
 Name of Employer: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Acknowledgement of Receipt of Notice of Privacy Practices (HIPPA)**

By signing below I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form.

Patient Name: \_\_\_\_\_

Signature \_\_\_\_\_ Relationship if other than patient: \_\_\_\_\_

**Insurance Information** Please be prepared to give your insurance card(s) to the receptionist. This will be scanned into our system to enable us to submit claims to your insurance company on your behalf.

**Primary Insurance Company:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

**SUBSCRIBER INFORMATION FOR THIS POLICY**

Last Name: \_\_\_\_\_ Home Telephone ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Jr Sr Work Telephone ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell Telephone ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
Gender:  Male  Female  
City \_\_\_\_\_ State \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Zip Code \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Certificate or Policy #: \_\_\_\_\_ Relationship to Insured:  Self  
Group Name: \_\_\_\_\_  Spouse  
Group #: \_\_\_\_\_  Child  
Name of Employer: \_\_\_\_\_  Other: \_\_\_\_\_

**Secondary Insurance Company:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

**SUBSCRIBER INFORMATION FOR THIS POLICY**

Last Name: \_\_\_\_\_ Home Telephone ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Jr Sr Work Telephone ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell Telephone ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
Gender:  Male  Female  
City \_\_\_\_\_ State \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Zip Code \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Certificate or Policy #: \_\_\_\_\_ Relationship to Insured:  Self  
Group Name: \_\_\_\_\_  Spouse  
Group #: \_\_\_\_\_  Child  
Name of Employer: \_\_\_\_\_  Other: \_\_\_\_\_

**Tertiary Insurance Company:** \_\_\_\_\_ **Effective Date:** \_\_\_\_\_

**SUBSCRIBER INFORMATION FOR THIS POLICY**

Last Name: \_\_\_\_\_ Home Telephone ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Jr Sr Work Telephone ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
Address: \_\_\_\_\_ Cell Telephone ( \_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_  
Gender:  Male  Female  
City \_\_\_\_\_ State \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Zip Code \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Certificate or Policy #: \_\_\_\_\_ Relationship to Insured:  Self  
Group Name: \_\_\_\_\_  Spouse  
Group #: \_\_\_\_\_  Child  
Name of Employer: \_\_\_\_\_  Other: \_\_\_\_\_

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS, AND REQUEST PAYMENT OF BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS OR PARTICIPATES.

Signed \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I UNDERSTAND THE PROVIDER'S CHARGE MAY EXCEED THE INSURANCE PAYMENTS, AND IF GREATER THAN SUCH PAYMENT, I WILL BE RESPONSIBLE FOR THAT AMOUNT. SHOULD MY ACCOUNT EVER BECOME DELINQUENT AND ELIGIBLE FOR COLLECTION, I UNDERSTAND AN APPROPRIATE COLLECTION FEE WILL BE ASSESSED.

Signed \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_