Premier Dermatology 2026 N. Beech Daly Rd Dearborn Heights, MI 48127
Phone :(313) 359-7900 FAX:(313) 359-7800

Premier Dermatology — Registration Information — Farid Nasser, MD

MR. MRS. MS. DR. _____ _____ _____
LAST NAME FIRST NAME MIDDLE INITIAL

_____
STREET ADDRESS CITY STATE ZIP CODE

_____ _____ _____ _____
BIRTHDATE SOCIAL SECURITY MARITAL STATUS NAME OF SPOUSE OR GUARDIAN

_____ _____ _____
EMAIL ADDRESS HOME PHONE CELL PHONE

_____ _____ _____
EMPLOYER OCCUPATION WORK PHONE

_____ _____ _____
NAME OF EMERGENCY CONTACT PHONE NUMBER RELATIONSHIP

IF WE NEED TO CONTACT YOU REGARDING BIOPSY RESULTS OR APPOINTMENTS, MAY WE:
LEAVE A MESSAGE ON ASWERING MACHINE AT HOME ON THE CELL PHONE: YES NO
CALL YOUR PLACE OF EMPLOYMENT: YES NO
CONTACT YOU BY EMAIL: YES NO

Insurance Information

WHO WILL BE RESPONSIBLE FOR PAYMENT FOR MEDICAL SERVICES RENDERRED, IF NOT COVERED BY INSURANCE OR H.M.O.? (SUCH AS A COPAY OR DEDUCTIBLE) _____

PRIMARY INSURANCE _____ CONTRACT #_____ GROUP _____

CARD HOLDER'S NAME / BIRTHDATE _____

CARD HOLDER'S SOCIAL SECURITY NUMBER: _____ RELATIONSHIP _____

SECONDARY INSURANCE _____ CONTRACT #_____ GROUP _____

CARD HOLDER'S NAME / BIRTHDATE _____

CARD HOLDER'S SOCIAL SECURITY NUMBER: _____ RELATIONSHIP _____

LIFETIME INSURANCE AUTHORIZATION

I authorize the release of any medical information to process any insurance claims relating to past, present and future medical examinations, tests, treatments or other services rendered by Premier Dermatology or Farid Nasser M.D. or any other person employed by Premier Dermatology.

I authorize the payment of medical or other benefits for all such services to be paid to Farid Nasser M.D.

If my medical insurance company does not pay for such services within 60 days after services were rendered, for any reason, including the reason of no medical necessity, then I promise to pay Premier Dermatology or Farid Nasser M.D. for such services.

I request that payment of authorized Medicare benefits, or any other health insurance or managed care plan, be made on my behalf to PREMIER Dermatology or Farid Nasser M.D. for any service furnished to me by Farid Nasser or any other person employed by Farid Nasser M.D. or PREMIER Dermatology. I authorize the holder of medical information about me to release to the centers for Medicare and Medicaid Services and its agents or any other health insurance or managed care plan that I have, any information needed to determine these benefits payable for related services.

SIGNATURE: _____ (Patient, Parent, Guardian) DATE:_____

FOR PATIENTS WITH NO INSURANCE:
I will personally responsible for full payment of medical care at the time service is rendered.
SIGNATURE: _____ (Patient, Parent, Guardian) DATE:_____